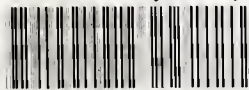


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A PROPOSAL FROM ETHIOPIA

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ELISABETH SCHAUER

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# **Paradigm Shift in Female Genital Mutilation A Proposal from Ethiopia**

By

Elisabeth SCHAUER  
M.A. Ludwig-Maximilians Universität, 1991

A Thesis Presented to  
The Faculty of the Department of Epidemiology and Public Health

Yale University

In Candidacy for the Degree of  
Master of Public Health

1996





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Elisabeth Chaudo  
Signature of the Author

May 24, 1996  
Date



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## Abstract

A qualitative descriptive study design was chosen to examine the perceptions, beliefs and attitudes of health workers, members of the National Committee on Traditional Practices of Ethiopia (NCTPE) in Addis Abeba and Jijiga, as well as women and men from Jijiga town, a community in Somali National State of Ethiopia, towards female infibulation. In semi-structured interviews as well as focusgroups, with overall 69 participants, the readiness and willingness of the local Somali population towards ending this traditional practice and towards identifying practical cultural ideas for action were examined. The findings of this ethnography give insight into the current prevalence of the practice, reasons for its persistence, causes for male and female changes of perceptions and locally developed solutions for the ending of female infibulation. Based on the study a hypothesis is generated and a project proposal is introduced. The proposal, which was developed by the women of the local community, indicates a willingness by both local men and women to end the current practice of infibulation. Ethical concerns towards current 'eradication' strategies are discussed and arguments for a culturally sensitive application of international human rights are presented. This paper draws the conclusion that the international formulation of a new circumcision policy is urgently needed in order to legitimize and encourage the development of effective programs that are actively designed, created and operated by indigenous people at grass-roots level.





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*"I have been circumcised pharaohnically. My daughter, who is 17 now, has not been circumcised. I told her she didn't have to be grateful to me for anything in her life, except that she is uncircumcised".*

*- a married woman, Sudan*

*"Oh, I am so afraid now. How will it be on my wedding day when I will be opened? I am scared now. Will it be painful? I will be thinking of this now. Tell me what should I do? I always had so much pain and now there is more to expect?"*

*- a young Somali woman, infibulated*

*"Are you circumcised yourself? What are the women doing in your country? Tell us, what should we do now? Who is to change? Should all the world get accustomed to the tradition of circumcision or should we change? What can be done?"*

*- Somali man, after the interview*



## 1. Statement of Problem

On April 15, 1996 the story of a woman who fled her homeland of Togo to avoid genital mutilation and seek asylum in the United States of America made the front page of 'The New York Times' (NYT 1996). Incidences like this clearly demonstrate that female genital mutilation (FGM) is no longer the issue of certain Sub-Saharan countries but increasingly a concern of global interest.

FGM is practiced in 26 African countries. The World Health Organization (WHO Feature 1995) estimates that currently up to 115 million women have undergone female circumcision. About 6000 girls are newly circumcised per day or 5 per minute.

In Ethiopia's Somali National State (bordering region to Djibouti and Somalia), the practice of infibulation, which is the most severe form of female genital mutilation, is as prevalent as 99 percent in 1995.

Infibulation is the cause of an immense number of physical and mental health complications to women. According to the present study, this traditional practice can be related to an estimate of up to 40 percent of female in-patients in the hospital of the researched community of Jijiga town, who are treated because of infibulation related illnesses only.

The effects of FGM deprive women of their right to health and well-being from the time the procedure is performed (at age 6-11), to the time of their menopause and beyond. In other words it affects more than 85 percent of a woman's entire life-span, given that life expectancy at birth is estimated to be 47,5 years (Human Development Report 1995).





International organizations, UN agencies and donors made a great effort in the past to educate the population about the dangers of FGM, create awareness within the communities concerned and disseminate information among their health professionals. The outcomes of these interventions prove a relatively small but nevertheless resource consuming impact. The above mentioned proponents of 'eradication' and 'elimination' campaigns (as outlined in Executive Directives like the 'Joint UNICEF/WHO/UNFPA Statement 1995') believe that any other form of action against infibulation violates internationally agreed upon human rights (Donnay 1996). UN agencies are also not willing to 1) draw distinctions between different forms of female circumcision like Muslim law long suggests; and, 2) see the similarities of certain forms of female circumcision with male circumcision, as suggested by the Koran.

The current denial of help and support by medical personnel seems to drive the practice underground and make the operations increasingly unsafe (e.g. use of syringes by untrained personnel) and the performance of the practice increasingly unequal, given the growing urban/rural and rich/poor disparity (see chapter 4; Dirie 1991; Dorkenoo 1994; Armstrong 1994). Traditional circumciser in rural communities are anxious to continue the practice because they have a vital financial interest and thus influence their communities accordingly (Raedda Barnen 1994).

Outlawing infibulation as a single measure has not proven to be an effective measure over time. It was tried in the nineteen-fifties in other Sub-Saharan countries, like Sudan and showed that 20 years later the practice was more prevalent than before (Shandall 1967; El-Dareer 1979).



Infibulation is a very old traditional practice (estimated to be performed for more than 2000 years) and is deeply imbedded in Somalian culture. Thus it has to be recognized in its social and cultural context. Being infibulated or not will (among other) determines a girl's matrimonial status, as well as her family's societal standing, dignity and honor (Jugessur 1993).

The need for practical projects on grass-roots level is enormous and often stated (Dorkeeno 1994). A step-by-step approach with the intention of harm reduction seems warranted but hindered by current international circumcision policies.





## LITERATURE REVIEW

### 2. Background Information on Female Genital Mutilation

#### 2.1. Geographical Distribution of Female Circumcision in Africa

This paper focuses on the practice of infibulation<sup>1</sup> in Ethiopia's Somali National State, a region bordering Somalia in the east and south and Djibouti in the north. In order to gain a larger impression of the geographical distribution of female genital mutilation (FGM) in general, a brief look at the entire African continent is presented.

First of all it is important to understand how mutilation is defined:

"Any definite and irremediable removal of a healthy organ is a mutilation. The female external genital organ normally is constituted by the vulva, which comprises the labia majora, the labia minora or nymphae, and the clitoris covered by its prepuce, in front of the vestibule to the urinary meatus and the vaginal orifice. Their constitution in female humans is genetically programmed and is identically reproduced in all the embryos and in all races. The vulva is an integral part of the natural inheritance of humanity" (Zwang in: MRG 1992).

The World Health Organization estimates that in 1995, 85 to 115 million girls and women have globally undergone female genital mutilation (WHO Feature 1995) with an annual increase of about two million per year, mainly due to population increase (Toubia,

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<sup>1</sup>Infibulation is the most severe form of the various types of female genital mutilation. Please see chapter 2.3. and App.A, Fig.5/6 for further explanations. The terms *female genital mutilation* and *female circumcision* are used synonymously throughout the text.



IJGO 1994). This correlates to 6000 new cases per day or 5 girls per minute. In Ethiopia's Somali National State this translates to 5 million girls who are currently candidates for circumcision<sup>2</sup>

Female genital mutilation is reported in at least 26 African countries that form a continuous belt across the northern sub-Saharan region from Sudan to Senegal, and along the Nile valley from Egypt to East Africa (see App.A, Fig.3/4 for map of distribution)<sup>3</sup> The variation in prevalence among countries ranges from 5 percent in Uganda and Zaire, to almost 100 percent in Somalia, Djibouti and the Somali part of Ethiopia which is called 'Somali National State'. The types of circumcisions performed vary widely both among and within countries (Toubia, IJGO 1994; see chapter 2.3. as well as App.A, Fig.3/4)<sup>4</sup> A study in Northern Sudan showed a prevalence distribution of 83 percent of infibulation, 12 percent with intermediate circumcision, 2.5 percent of women had a 'sunnah'-type (mildest form) and 2 percent were unsure of the type performed (El Dareer 1983b). Similar rates have been reported in Somalian women (Dirie 1991) and can probably be expected for the

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<sup>2</sup>Estimated prevalence rates of circumcision have been developed from reviews of small limited studies, country reports and, if available, national surveys, all with varying degrees of validity. Currently there are no comprehensive base-line data on FGM. Most data are statistical estimates of FGM in Africa, in many cases based on anecdotal information.

<sup>3</sup>The wide belt composing the African populations where circumcision takes place corresponds to those countries having some of the highest child and maternal mortality rates globally. These levels reflect deficiencies of medical care, of clean drinking water, of sanitary infrastructure and of adequate nutrition (Dorkenoo 1994; see App.B).

<sup>4</sup>Outside of Africa, FGM is seen in Oman, South Yemen, United Arab Emirates, and by the Moslem population of Indonesia, Malaysia, the Bohra Muslim in India, Pakistan and East Africa (Arbesman 1993; Dorkenoo 1994).



'Somali National State' in Ethiopia.

Immigration of African women to Europe, Canada, Australia and the United States in the past decade has brought the problems and controversies of female circumcision to these countries, and strongly intensified the world's attention to its health risks and the human rights issues involved<sup>5</sup>

Female circumcision has a severe impact on more than 85 percent of a woman's life. "It [FGM] is a practice which threatens the health and development of women, starting at the time the ritual is performed on the young girl and continuing throughout her entire life" (UNICEF Directive, 1994, 1).

The age at which the mutilations are carried out on girls varies from place to place. In some cultures, girls experience genital mutilation as early as seven days after birth while in others, the ceremony might not occur until the girl is of marrying age, approximately 14-16 years old. A general tendency has been for girls to be of a younger age at the time of the operation. As a result, most girls experience FGM between four and eight years of age which is the time when they are made aware of the social role expected of them as women. Most girls in Ethiopia's Somali National State are infibulated by the age of 6-11 years (see chapter 4).

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<sup>5</sup>The discussion around female circumcision in Western countries cannot be presented in this paper, as it would go totally beyond the scope of this paper. It has to be noticed though as an issue that will certainly have legal and social impact in many ways (e.g. asylum and immigration laws; New York Times front-page report, April 15, 1995).



## 2.2. Historical Trends

The customs and beliefs surrounding the evolution of the various forms of female genital mutilation are widespread. It is not possible, as yet, to conclude whether the practice originated in one area or evolved independently in several regions of the world<sup>6</sup> There are two competing explanations. The first is that research has found evidence of the existence of infibulation practices in ancient Egypt, and that it was perhaps there that the custom originated (Assaad 1979). The alternative explanation is that it could have been an old African puberty rite that came to Egypt by diffusion<sup>7</sup> (Dorkenoo 1994). Certainly, the practice was widespread in the pre-Islamic era in Egypt, Arabia and the Red Sea coasts. A WHO report states that female circumcision was recorded as early as the fifth century B.C. by Herodotus and practiced among the Phoenicians, Hittites and Ethiopians (Taba 1979).

Presently, opinions are divided as to whether or not the practice is disappearing and if so due to what measures (legislation, social changes, economic impact, etc.). It is generally assumed that female circumcision as a cultural tradition is decreasing, but in fact

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<sup>6</sup>There are multiple examples in history showing that female sexuality has always been repressed in a variety of ways: female slaves in ancient Rome had a ring put through their labia majora; the tradition of 'chastity belts' in Europe in the 12 th century; and clitoridectomy as a remedy against masturbation in the beginning of the century in Europe and the US.

<sup>7</sup>Infibulation is known in Sudan, Djibouti and Ethiopia as 'pharaohnic' circumcision; and in Egypt it is referred to as 'Sudanese circumcision'.





very slowly, with millions of excisions still taking place. Another assumption is that the practice is done at an earlier and earlier age, so that the children are 'too young to resist'.

Amongst 'urban elite' in some African countries genital mutilation seems increasingly unpopular and men are sometimes willing to marry uncircumcised women (Koso-Thomas 1987). Civil wars and internal as well as external displacements of great numbers of people in Sub-Saharan Africa (especially in Ethiopia, Somalia and Eritrea) seemed to hasten more rapid changes (Dines 1980; see also chapter 5.2.3.).

As a result of media and public education campaigns since the mid-eighties, the taboo surrounding the public mention of the practice has been broken. There is an increase in public awareness of the harmful effects of female genital mutilation. There is no evidence, however, that circumcisions are dying out. They seem to continue especially in remote/rural areas and still get shifted to other geographical locations<sup>8</sup>

In Somali National State (Region 5) of Ethiopia, infibulations are still widely practiced among the Somali population (99%) (see chapter 4.1). In 1994 a local journalist and head of women's affairs in this region was asked about the present attitude of the communities: "According to the information I have been able to piece together, these practices will not go away on their own, as some people claim" (NCTPE Newsletter 1994).

In the main, the practice continues to be widespread among large sectors and

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<sup>8</sup>Urban women in Wau, Sudan, for example, recently started to practice infibulation, even they had no such traditional history; also the converted Moslem women in southern Sudan, who marry northern Sudanese men have begun the practice of FGM (Ismail 1990).



groups within Africa. Those in favor of it are noted to be a passive majority who hark back to traditional society (UN 1986). In any case, absolute numbers of girls affected by genital mutilation are estimated to be increasing. Rapid population growth in Africa means that greater numbers of female children are born and in turn, are exposed to the risk of mutilation.



### 2.3. Types of Circumcision

FGM can be classified into three broad categories (see Appendix A, Fig.5/6 for representations): 'sunnah'-circumcision; clitoridectomy: Type I and II; infibulation: Type III and IV

In reality, of course, circumcision has all forms of intermediate cuttings in various degrees done according to the tradition and the individual demand of the girl's relatives, as well as the experience and 'skills' of the circumciser.

The mildest type of circumcision is known as 'sunnah circumcision'. 'Sunnah' is a word originating from the Koran, meaning 'tradition' or 'following the traditions of the Prophet Mohammed'. It can also mean simply a custom at the time of Prophet Mohammed. It is often described as the piercing of the hood or prepuce of the clitoris or the removal of parts of the skin around the clitoris. It is the mildest type of circumcision<sup>9</sup> Such a procedure would be comparable to male circumcision, as it does represent a mutilation of the child's body but it does not imply the removal of the clitoris. Unfortunately, most of the time the removal of parts of the clitoris is intentionally or unintentionally involved as the circumciser's anatomical knowledge, surgical skills and quality of instruments (old knives or razor blades) as well as eye-sight are limited.

Clitoridectomy Type I, involves partial or total amputation of the clitoris. When clitoridectomy is accompanied by partial or total excision of the labia minora the operation

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<sup>9</sup>According to the religious wording, 'sunnah' circumcision is advisable not mandatory. Religiously speaking it has man's perfection as a purpose, it shows devotion to God and purifies the body (Aldeeb 1994).



is termed excision, or Type II. Bleeding from the raw surfaces and from the clitoral artery is secured with a few stitches of thorn, or by application of hemostatic poultices made of herbs, ash, mud, coffee ground, egg white/yellow or dung (Toubia, IJGO 1994).

Modified infibulation, or Type III, is a milder form of infibulation with the same amount of amputation, as Type IV but the incision of the labia majora is limited to the upper two-thirds, thereby leaving a larger posterior opening. Total infibulation, or Type IV operation, involves the removal of the clitoris and the labia minora, plus incision of the labia majora, to create raw surfaces which are stitched together to cover the urethra and the entrance to the vagina leaving a small opening for the passage of urine and menstrual blood in the size of a piece of corn-kernel<sup>10</sup> (Toubia, IJGO 1994; El Dareer 1983a). In some instances a tiny sliver of wood or reed is inserted to preserve an opening for urine and blood. The girls legs are usually bound together from the ankle to the knee until the wound has healed, which may take up to 40 days (WHO 1986).

### 2.3.1 Description of an Infibulation

The following description of an infibulation in Djibouti (David 1978) is similar to other findings in the literature, video-documentations and the author's own research findings in Jijiga-town, Somali National State. It gives a good representation of what steps are performed:

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<sup>10</sup>Again, as this system seems anatomically very precise it is also simplified. In reality, the extent of cutting and stitching varies considerably, since the operator is usually a lay-person with limited knowledge of anatomy and surgical technique. With local or mostly no anesthesia, the girl may move, and the extent of cutting cannot be accurately controlled.





"The little girl...is immobilized in the sitting position on a low stool by at least three women. One of them with her arms tightly around the girl's chest; two others hold the child's thighs apart by force, in order to open wide the vulva. The child's arms are tied behind her back, or immobilized by two other women guests.

The traditional circumciser says a short prayer: "Allah is great and Mahomet is his Prophet. May Allah keep away all evils" Then she spreads on the floor some offerings to Allah: maize or, in urban areas, eggs. Then the old woman takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip. This nymphectomy and scraping are repeated on the other side of the vulva.

The little girl howls and writhes in pain, although strongly held down. The operator wipes the blood from the wound and the mother, as well as the guests, "verify" her work, sometimes putting their fingers in. The amount of scraping of the large lips [as well as overall cutting] depends upon the "technical" ability of the operator. The opening left for urine and menstrual blood is minuscule.

Then the operator applies a paste [herb extracts, ashes, cow-dung, egg, etc.] and ensures the adhesion of the large lips by means of an acacia thorn, which pierces one lip and passes through into the other. She sticks in three or four in this manner down the vulva. These thorns are then held in place either by means of sewing thread or with horse hair. Paste is again put on the wound.

But all this is not sufficient to ensure the coalescence of the large lips; so the little girl is then tied up from her pelvis to her feet: strips of material rolled up into a rope immobilize her legs entirely. Exhausted, the little girl is then dressed up [in her new 'little brides dress'] and put on a bed. The operation lasts from 15 to 20 minutes according to the ability of the old woman and the resistance put up by the child"



## 2.4. Physical Complications resulting from Infibulation

Female genital mutilation is a major contributor to childhood and maternal mortality and morbidity in communities with poor health services (Toubia, IJGO 1994); which is true for the entire Somali National State (see App.B, Table 1/4).

The specialized sensory tissue of the clitoris is concentrated in a rich neurovascular area of a few centimeters. This means that the removal of only a small amount of this richly blood-supplied tissue is very dangerous and has serious and irreversible effects. The complications can be divided into early (short-term) problems and late (long-term) and occur most frequently with infibulations (WHO 1986). Other factors that determine individual health risks are hygienic conditions, the skills and eyesight of the operator, and the struggles of the child.

### 2.4.1. Short-Term Complications

Common short-term effects are hemorrhaging from the section of the internal pudental artery or the dorsal artery of the clitoris; and severe pain which can lead to post-operative shock and death<sup>11</sup>. Bad eyesight of the operator or the resistance of the child causes cuts in other organs: the urethra, the bladder (resulting in urine retention and bladder infection), the anal sphincter, vaginal walls or Bartholin's glands (Dorkenoo 1994).

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<sup>11</sup>It is impossible to estimate the number of deaths, since the nature of the operation requires that unsuccessful attempts be concealed from strangers and health authorities, and a very small proportion of cases of immediate complications reach the hospital. Nevertheless, hospital staff in all the areas concerned are very familiar with last minute hopeless attempts to save patients (Dorkenoo 1994).



Prolonged bleeding may lead to severe anemia and affects the growth of a poorly nourished child. Local and systemic infections (wound-infections, abscesses, ulcers, delayed healing, septicemia, gangrene, tetanus, etc.) are also common, as the operation instruments have rarely been sterilized and are used on three to four girls in a row.

#### 2.4.2. Special Concern: HIV Infection

There is, as yet, no scientific evidence that FGM leads to increased risk of HIV infection, but this has not been the subject of detailed research. The National Committee on Traditional Practices in Ethiopia stated in their 1994 Newsletter that: "From recent studies it has emerged that the women subjected to genital mutilation are more often victims of sexually transmitted diseases, especially AIDS" (NCTPE Newsletter 1994, 8). Unfortunately these sources are not further mentioned in the paper and the author's own search for studies, pilot-surveys, estimates or baseline data has not been successful in identifying data explicitly related to FGM and HIV infection. Therefore, to the author's knowledge there exists an urgent need for research into any possible link of this widely prevalent practice to HIV infection on a continent with rapidly rising HIV infection rates.

In order to relate HIV infection with circumcision, various scientific results have to be taken into account. There is evidence that bleeding and open wounds increase the likelihood of infection in general. During the procedure of infibulation a high risk of transmission of other infectious agents could be shown, e.g. tetanus. At the day of the ceremony not only one, but up to five girls at a time are circumcised. The circumciser, mostly an old woman from the local village with no knowledge whatsoever about hygienic



measures and sterilization, will re-use her cutting instruments (knife or razor-blade) without cleaning between operations. Further, infibulation is known to damage the sexual and reproductive organs, often due to the circumciser's bad eye-sight and the girls resistance. Cuts in the urethra, the bladder, the anal sphincter, the vaginal walls and the Bartholin's glands are common (Dorkenoo 1994). On the day of the marriage the woman is re-opened by her husband with a knife or a sharp instrument and the birth of every child involves further cutting and re-infibulating. Each re-opening increases the chance of infection, which in theory can increase infection by HIV. This is especially since after the husband 'opens' his wife in the wedding night, the couple is encouraged to have frequent intercourse during the first weeks of marriage in order to prevent a closing of the wound.

"According to the tradition, the husband should have prolonged and repeated intercourse with her during eight days. This 'work' is in order to 'make' an opening by preventing the scar from closing again. During these eight days, the woman remains lying down and moves as little as possible in order to keep the wound open.." (David 1978).

In some cases where tight infibulation prevents vaginal intercourse, anal intercourse (Sami 1986) or the penetration of the meatus (Shandall 1967) is used as an alternative; again the resulting damage of the tissue is a possible route of infection by HIV (Dorkenoo 1994).

There is further evidence that circumcision patterns are changing. Due to parents' growing demand, the circumcisers are increasingly trying to find syringes and anesthetics. Not trained in giving injections, it often takes the circumciser several attempts to place a puncture and again the syringe is used for multiple operations without sterilization.





### 2.4.3. Long-Term Effects

Long-term effects are especially associated with infibulations due to the obstruction of urine and menstrual blood flow. Chronic infections of the uterus and the vagina are frequent, as the vagina becomes a semi-sealed organ; causing pelvic and back pain and eventually infertility (Sami 1986; El Dareer 1983b). Chronic urinary tract infections can lead to urinary stones and kidney damage. The most common long-term complication is the formation of dermoid cysts and keloids in the line of the scar. Keloid scar formation on the vulval wound can become so enlarged as to obstruct walking. Sometimes a large foreign body forms in the interior of the vagina as the result of the accumulation of mucous secretion. The growth of implantation dermoid cysts as large as a grapefruit are not rare (Dorkenoo 1994). As it is very disfiguring, it causes anxiety, shame and fear in women who think that their genitals are regrowing in monstrous shapes or who fear they have cancer.

Extremely painful menstruations (dysmenorrhea) are very common, since menstrual blood can not escape freely and young infibulated girls try to dislodge their accumulated clots with the nail of the small finger. Cases are reported in which infibulated, unmarried girls developed swollen bellies due to the complete obstruction of the menstrual flow. They are brought to the hospital with severe abdominal pain, an apparent absence of menstruation for months and the signs of uterus in labor. In one case, after performing de-infibulation, more than 3 liter of blackish foul-smelling blood was released (Dorkenoo 1994).

Childbirth adds a special risk for infibulated women, particularly where health



services are limited. It is estimated that the risk of dying during delivery is twice as high for the infibulated mother and fetal mortality is many times increased (Belsey, WHO in: Stelzenmueller 1995). If de-infibulation (bilateral or anterior episiotomy; see App.A, Fig.6) is not performed, the exit of the fetal head may be obstructed and strong contractions can lead to perineal tears. If contractions are weak and delivery of the head is delayed, fetal intra-uterine death or damage as a result of prolonged perinatal hypoxia and lack of resuscitation can occur (Sami 1986; MRG 1983). A study in 1989 showed that there was a significant increase in the occurrence of severe asphyxia in the infants born to infibulated women (DeSilva 1989)<sup>12</sup> In case the episiotomy is made by non-professional helpers, other structures may be injured: the vagina, cervix or rectum of the mother, or the scalp or other parts of the baby.

Traditionally, re-infibulation is performed after delivery of the fetus and placenta, and the posterior opening is reconstructed to a size similar to that of the virginal state<sup>13</sup> This may be done up to 12 times (Dorkenoo 1994).

De-infibulation may also be necessary for the first intercourse. The procedure may be done by an untrained midwife/circumciser<sup>14</sup> or often by the husband himself on the

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<sup>12</sup>No long-term follow-up has been done on the effects of circumcision-induced perinatal hypoxia on children's development until present.

<sup>13</sup>Of course this procedure again brings up ethical conflicts e.g., in countries where female circumcision was made illegal, re-infibulation is correspondingly interpreted as illegal. Many infibulated women want a re-infibulation and medical professionals should not ignore the woman's feelings and beliefs.

<sup>14</sup>At times the circumciser uses a clay model of the husband's erect penis to model the vaginal opening of his wife accordingly.



wedding-night using his fingers, a razor blade or a knife<sup>15</sup> (WHO 1986). Mutilated women often feel severe pain during intercourse (dyspareunia), especially when painful stitch neuromas have developed as a result of the entrapment of nerve endings in the scar.

Necrosis of the septum between the vagina and bladder can cause vesico-vaginal fistula, a distressing condition of urinary incontinence for which women are often ostracized by their communities (Toubia, IJGO 1994; Dorkenoo 1994). Later in life, many mutilated women are continually 'dribbling urine'. This incontinence has enormous socio-medical impacts. Women feel extreme shame about their condition, they mostly stop attending social gatherings, are divorced by their husbands, are severely handicapped in carrying out their normal duties and at times have to earn their living as beggars (Sami 1986).

## 2.5. Sexual Effects and Psychological Consequences

Research and documentation on the sexual and psychological effects of female circumcision is still very limited. There is no surgical technique capable of repairing a clitoridectomy, or of restoring erogenous sensitivity. The *glans clitoris*, with its specific

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<sup>15</sup>No study has ever been done on how much the newly married men know about female anatomy; whether the men know where to cut and how to perform the cutting; whether they are informed about the procedure by older men and whether they know about means of avoiding infections, stopping unexpected bleedings, etc. In the author's opinion this area constitutes an important future research field, as health education might have a significant impact on hygienic behavior.



sensory apparatus, is a primary erogenic zone. When it has been reduced to an area of scar tissue, no orgasm can be released by its manipulation. It has been proven that all orgasms in women originate in the clitoris, although they may be felt elsewhere (Masters 1966; The Boston Women's Health Collective Inc., 1978).

Almost all types of female circumcision involve the removal of parts or the whole clitoris, the main female sexual organ, equivalent in its anatomy and physiology to the male organ, the penis. Even if the procedure is done under hygienic conditions, it constitutes a medically unnecessary removal of a functional organ. Moreover, in accordance with human right declarations, the potential loss of sexual function constitutes a violation of the right to physical and mental integrity (Joint Statement 1995).

Obviously a woman's sexuality is affected according to the extent of the operation and the degree to which other social messages inhibiting sexual expression are internalized. The relationship between the degree of anatomical damage and the ability of women to compensate for it through other sensory areas or emotions or fantasy is not well understood (Karim 1965). Sexual dysfunction in both partners may be the result of painful intercourse and reduced sexual sensitivity on the side of the woman. It is questionable whether men get any satisfaction from intercourse with infibulated women whose tight openings are thought to be desirable. In fact one study in Sudan shows the opposite, that husbands with at least one infibulated and one non-infibulated or 'sunnah' circumcised wife, preferred the latter sexually. The men stated that they enjoyed intercourse with them more because their wives seemed to share with them the desire, the act and the pleasure (Shandall 1967). In other studies, increased male drug use and female





excision could be linked, as female circumcision distorts sexual relations and very few men can succeed in bringing their wives to orgasm. The husbands were found to resort to drugs and narcotics in order to be able to hold their erections as long as possible (Aldeeb 1994).

It can be estimated that among girls who live in communities where female circumcision carries high social value, the desire to gain social status, please parents, and comply with peer pressure balances the fear, trauma and after-effects of the mutilation. But whatever the 'societal value' of the operation, the experience is a deeply personal one and opponents of female circumcision argue that:

"..the little girl who is excised, even if she wants it because all the girls of her age are done and because she has been persuaded, doesn't feel any less the terrifying pain. Moreover, she feels deeply the hurt done to her body. She is conscious of being wounded, diminished specifically. Whatever else may be suggested, she experiences a mutilation.." (Awa Thiam 1978 in: Dorkenoo 1994, 25).

Personal accounts and research findings repeatedly contain references to anxiety, terror and unbearable pain; the subsequent sense of humiliation and of being betrayed by parents. On the other hand, there are references to special clothes and good food associated with the event, to the pride felt in being like everyone else, in being 'made clean' and having suffered without screaming (Dorkenoo 1994). A study focusing on the perception of pain and the code of behavior surrounding pain in a West-African tribe showed that parts of the women's socialization process, particularly circumcision, signal and strengthen courage and bearing of pain as crucial cultural values (Sargent 1984).



FGM may leave a lasting mark on the life and mind of the woman who has undergone it. The psychological complications may be submerged deeply in the child's subconscious mind, and may trigger the onset of behavioral disturbances.

Psychopathologic disorders directly related to circumcision are often subtle and buried under layers of denial, resignation and acceptance of social norms. Women may suffer feelings of incompleteness, anxiety, depression, chronic irritability, frigidity or marital conflicts. Many women traumatized by their experience of FGM may have no acceptable means of expressing their fears, and suffer in silence (Joint Statement 1995).

Amongst infibulated women a syndrome of 'genitally focused anxiety-depression' can arise from constantly worrying over the state of their genitals, intractable dysmenorrhea, and the fear of infertility (Toubia, NEJM 1994; Toubia, IJOG 1994). Also, chronic irritability, reactive depression, hallucinations and psychosis have been reported (Sanderson 1982).

Understanding the personal psycho-social balancing act that every woman has to complete in order to live with the consequences of this operation and the community dynamics of accepting circumcision is important, not only in uncovering psychopathologic disorders but also in comprehending why the practice continues and what the reinforcing mechanisms are. Such an understanding and a careful and sensitive analysis of changes as well as their acceptance is central to the design of messages against the practice.

Today there is, for example, a noticeable shift in the ritual and cultural meaning of



circumcision. As a result there seems to be a trend to circumcise at a far younger age and the child's role does not automatically change after the mutilation. The ritual ceremonies of initiation and development into adulthood are also beginning to disappear somewhat. In the absence of symbolism, with no feeling of 'stepping into a new life', and stripped of the rejoicing of the community, the psychological damage is likely to be more grave and the physical pain harder to bear (Dorkenoo 1994).

To be different produces anxiety and mental conflict, in many ways. This brings up the topic of circumcised women who immigrate into societies where the procedure is not performed. Serious problems in developing their personal and sexual identity may evolve and health professionals will be called on to deal with these problems. On the other hand it is believed that, un-excised, non-infibulated women within a culture where it is traditionally performed, are despised and made the target of ridicule, and no one in the community will marry them. In tight, traditional village communities an uncircumcised girl most certainly will suffer psychologically.



## 2.6. Cultural Meaning of Female Circumcision

The presented beliefs must be understood in context of societies where female virginity is an absolute prerequisite for marriage, and where extramarital relationships provoke the most severe penalties. Non-excised girls are ridiculed, and forced to leave their communities and regardless of their virginity have little or no chance of marriage. Even if the reasoning seems conflicting with social, biological and medical realities, it is important to take notice because they are deeply believed in with tenacity.

The following is a collection of reasons commonly given by communities or societies who practice FGM (Jugessur 1993; Dorkenoo 1994; Aldeeb 1994).

### 2.6.1. Traditional Sociological Meaning:

- In many areas circumcision marks the initiation from childhood into adulthood. Elaborate ceremonies surround the occasion. Special songs, chants and dances teach the girl her duties and desirable characteristics as a wife and mother. There is always a ritual of changing cloth after circumcision has taken place and offering of special food.
- The preservation of virginity. The economic 'value' of a girl depends on the bride price she fetches, which again depends on her virginity and the type of circumcision. Infibulation is of highest economic value and increases the girl's matrimonial status greatly, whereas uncircumcised women have no chance of finding a husband. In certain cases the bride price goes up if the vagina is very





tightly closed. If for some reason the husband is not satisfied with the tightness of the vaginal opening, the girl is returned to her parents. It is said that the operation serves the purpose of enabling the potential mother-in-law to discover whether or not the girl is a virgin:

"If she is found not to be a virgin, the husband-to-be has the right to reject her and refuse to go along with the marriage. A row ensues and a refund of the dowry has to be made. The disgraced family is stigmatized, and the girl may have to leave home to find a husband outside the community. (Ogunmodede in: Dorkenoo 1994, 14).

- The preservation of family honor and the membership to a certain cultural group.

In Sub-Saharan countries a family does not merely consist of mother/father/siblings, but can encompass as many as 40 members. One uncircumcised girl in a family can lead to the complete ostracism of the whole group from the community.

#### 2.6.2. Traditional Psycho-Sexual Meaning:

- Infibulation is believed to bring increased sexual pleasure to the man.
- The prevention of the woman's promiscuity and adultery later in life. Girls and women are believed to be unable to control their sexual desires, so if they are not circumcised, their parents force them into temptation, suspicion, disgrace, promiscuity and further prostitution. For women to enjoy sexuality is a matter of shame. Infibulation often makes sexual intercourse very painful and minimizes the



sexual desire of women. Therefore circumcision helps the woman to remain shy and virtuous; as it is believed that "in the Orient where the climate is hot a girl gets easily aroused if she is not circumcised, this makes her shameless and prey to her sexual instincts" (Jugessur 1993).

- Uncircumcised girls are believed to be restless, aggressive and frantic.

Circumcision is meant to calm them down. Especially in societies where a man has several wives, it is said that since it is physically impossible for him to satisfy them all, it helps if they are not too demanding.

#### 2.6.3. Traditional Ideas about Hygiene, Health and Biology:

- The maintenance of cleanliness. Glands in the vagina and clitoris are believed to produce a bad smell and hence make the woman unfit to be touched. Circumcision is seen as a way to keep her and everyone else who comes in contact with her "clean"
- The pursuance of aesthetics. Female genitalia are in general thought of as being ugly to look at. Ethiopian women are believed to have a naturally enlarged clitoris which, when it comes in contact with the penis, makes the man impotent or can kill the first-born if the baby's head touches it during delivery. Also, it is an Ethiopian belief that if the female genitals are not excised, they will dangle between the legs like a man's. In some African countries women remove all bodily hairs to attain a smooth and therefore 'clean' body. The same sentiment appears to be one aim of



infibulation; to produce a smooth skin surface and a 'clean' sexual organ.

- Circumcision is also believed to make a woman's face more beautiful and make her more attractive for her husband; 'it gives her a glowing face'.
- To demarcate clearly the sex of the person the clitoris, representing the masculine element in a young girl, and the foreskin, representing femininity in a boy, must both be excised.
- The enhancement of fertility. It is believed that circumcised girls become pregnant very easily.
- The improvement of male sexual performance. It is believed that when the penis comes in contact with the clitoris, the excitement of the man leads to an early ejaculation.
- Female circumcision is believed to prevent vaginal cancer and the swelling of the clitoris which could drive the woman to masturbation or homosexual relationships.

#### 2.6.4. Traditional Religious Meaning:

- There is a belief that circumcision is demanding by Islamic faith (see chap. 2.7.). In many countries the Moslem population continues to believe that the non-excised woman is impure in a religious sense. The condition of being uncircumcised keeps impurity in the body and renders prayer 'null and void', the same way as an unclean mouth does. Therefore the goal of circumcision is to fulfill an act of worship and to be clean for prayer.



- Mysticism. Women who refuse to submit themselves to FGM have to live with the fear that the wrath of God or of supernatural powers will be brought upon them and their families. In contrast, circumcised women are believed to be always healthy and protected and cured from epilepsy, hysteria, insanity, melancholia and depression.

None of the above mentioned cultural reasons, together or separately, adequately explain why the custom has persisted, when many of the given reasons for it have disappeared or can easily be interpreted in a contrary way. Medically speaking, for example, to offer as a reason for infibulation the preservation of virginity is odd. Re-infibulation is easily done to look like the original one, whereas a ruptured hymen is more difficult to repair. Cases are reported from Somalia, of women paid for, married, divorced, re-infibulated, paid for and married again five times or more (Dorkenoo 1994). Shandall (1967) who researched on Sudanese prostitutes states:

"Infibulation does not confer any protection or deterrent action on females. Moreover, the vulval skin diaphragm, being an artificially constructed device, can always be reconstructed without any suspicion that this is not the original...in the writer's opinion, infibulation would encourage immorality rather than protect against it" (p. 190)

Equally plausible the argument of cleanliness can scientifically be balanced. In practice, infibulation clearly has the effect opposite to that of promoting hygiene, as urine and menstrual blood, result in discomfort, odor and infection when they cannot leave the body (Dorkenoo 1994).





Further, many reasons for circumcision are not given much credibility or attention even within the culture. A significant proportion of respondents in every survey cannot think of any reason at all why they do it, apart from the fact that it is done and that it has always been done. The thought that it could be a mutilation is foreign to them (Dorkenoo 1994; Aldeeb 1994).



## 2.7. The Koran

First of all, it is important to note that FGM is not religiously connected. It is practiced among Muslims, Catholics, Protestants, Copts, Jews, Animists and non-believers alike<sup>16</sup> In fact, it is remarkable that in the most fundamental Muslim countries the custom is no longer observed, e.g. Saudi-Arabia which is seen as the 'cradle of Islam' and the center of the Holy Lands. The more religiously educated and fundamental in their Islamic orientation the believers are, the less infibulation is likely to be performed in their society, except the 'sunnah' type. Dr.Taha Ba'asher from WHO<sup>17</sup> makes a clear statement about this:

"Nonetheless, it is important to emphasize here that in the absence of any clear reference in the Holy Koran and in confirmed traditions of the Prophet Mohammed, leading Islamic theologians, such as Sheikh Shaltout refuted the argument based on religious doctrine for the practice of female circumcision. Some of the confusion which may have arisen with regard to religious interpretation is probably due to generalization from male circumcision to the female. While there is a general consensus of opinion that male circumcision was one of the commands, when the Lord made trial of the Prophet Abraham, there is no clear indication in the case of female circumcision. Even the often quoted saying of prophet Mohammed to the traditional practitioner [circumciser], Om Atteya, advising her to reduce but not to destroy, was challenged as unreliable and unauthenticated<sup>18</sup> The Mufti of the Sudan, Sheik Ahmed

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<sup>16</sup>The majority of all ethnic groups in Ethiopia is familiar with the circumcision of women. The Amahara people for example perform a clitoridectomy instead of an infibulation.

<sup>17</sup>World Health Organization

<sup>18</sup>This woman, known as an exciser of female slaves, answered to Prophet Mohammed, as he asked her if she kept practicing her profession: 'I do, unless it is forbidden and you order me to stop doing it'. Mohammed replied: 'Yes, it is allowed. Come closer so I can teach you: if you cut, do not overdo it, because it brings more radiance to the face and it is more pleasant for the husband.1994) The part of the Koran where these lines are found is called a '*hadith*', meaning a orally delivered saying, of which the origin is doubtful. It is, for example, known that Prophet Mohammed's own daughters



El Taher, in reviewing the subject in 1946 [the year of the outlawing of circumcision in Sudan], clearly stated that the words 'embellishment', 'preferable' and 'commendable'<sup>19</sup> do not imply obligation" (Ba'asher in: Dorkenoo 1994, 13).

Sheik Abbas, Rector of the Muslim Institute at the Mosque of Paris, argues equally:

"If circumcision for the man - though not compulsory - has an aesthetic and hygienic purpose, there is no existing religious Islamic text of value to be considered in favor of female excision, as proven by the fact that this practice is totally non-existent in most of the Islamic countries. And if unfortunately some people keep practicing excision, to the great prejudice of women, it is probably due to customs practiced prior to the conversion of these people to Islam" (Aldeeb 1994).

#### 2.7.1. Religious arguments against female circumcision (by Aldeeb 1994)

- God does not mutilate

The argument that God is a purposeful and insightful creator is best described by the following quotation from an African woman who is, herself circumcised:

"If religion comes from God, how can it order man to cut off an organ created by Him as

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were not circumcised (Stelzenmueller 1995).

<sup>19</sup>Prophet Mohammed said: "Circumcision is a sunnah for the men and makrumah for the women" The term sunnah here means that it is conform to the tradition of Mohammed himself, or simply a custom at the time of Mohammed. In fact, male circumcision would be the sign which would differentiate the believer from the non-believer. Therefore, male circumcision was seen as 'the sign of Islam'. The term makrumah is far from clear, but can be translated into an honorable deed. Of course there have been added statements (religious narrations) by religious leaders like: 'Female circumcision is a makrumah, and is there anything better than a makrumah?' (Aldeeb 1994)



long as that organ is not deceased or deformed? God does not create the organs of the body haphazardly without a plan. It is not possible that He should have created the clitoris in a woman's body only in order that it be cut off at an early stage in life. This is a contradiction into which neither true religion nor the Creator could possibly fall. If God has created the clitoris as a sexually sensitive organ, whose sole function seems to be the procurement of sexual pleasure for women, it follows that He also considers such pleasure for women as normal and legitimate, and therefore as an integral part of mental health" (El-Saadawi 1980 in: Aldeeb 1994).

- Man should not attempt to change God's perfect creation

The argument put forward here is that: "He perfected everything He created" (verse 32:7; Aldeeb 1994). If God is satisfied with his creation, how can man believe to accomplish more?

- Do not harm purposefully

Sheik Hassan Ahmed Abu-Sahib (1984) made the most explicit argument known on the part of a contemporary religious Muslim leader. Following his advice, female circumcision should be banned because medical science has proven that it is harmful in many ways. The Koran clearly forbids man to harm himself by virtue of verse 2:195: "Do not throw yourselves with your own hands into disaster" and "Who harms a believer, harms me and who harms me, harms God" Further, even Prophet Mohammed himself could not be considered infallible on certain 'worldly' subjects: "You know your worldly business better [than I do]" and can therefore be contradicted by medical science (Aldeeb 1994).





- Woman have no foreskin, therefore no source of uncleanness

Purity is absolutely necessary for prayer as uncleanness renders prayer invalid.

Therefore circumcision becomes compulsory for men, as repugnant, greasy substances are secreted and kept under the foreskin<sup>20</sup>. Women, in turn have no foreskin and therefore no source of impurity.

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<sup>20</sup>Muslim scholars and authors feel so strongly about male circumcision, that they grant the women the right to dissolve the marriage and get a legal separation if the husband is not circumcised. The woman has the right to marry someone handsome and clean and an uncircumcised man can be a source of repulsion and a vector of diseases (Aldeeb 1994).



## 2.8. International Legislation and Human Rights Declarations (or which declarations are applicable in the case of FGM?)

A major international expression of the goal of equal rights for Women was taken in 1979, when the UN General Assembly adopted the 'Convention on the Elimination of All Forms of Discrimination Against Women'<sup>21</sup> [State parties are obliged to take:] 'All appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women' (Art. 5a).

The description available of the reactions of Children during circumcision - panic, shock from extreme pain, biting through the tongue, convulsions, necessity for a multiple of adults to hold down a small child, death - are indicative for a practice comparable to torture. Therefore Art.5 of the Declaration of Human Rights, applies to all countries where female circumcision is performed<sup>22</sup> Further, the 'Declaration of the Rights of Children (1959)', asserts that children should have the possibility to develop physically in a healthy and normal way in conditions of liberty and dignity. They should have adequate medical attention, and be protected from all forms of cruelty. Additionally, in 1990, the

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<sup>21</sup>Based on the 'Declaration on the Elimination of Discrimination against Women', 1967, Art.1,2 and 3

<sup>22</sup>Declaration on the Protection of all Persons from being subjected to Torture and other cruel inhuman or degrading Treatment or Punishment, 1975, Art. 2, 3 and 4'



United Nations Convention on the Rights of the Child went into force and became part of the International Human Rights Law. Art. 24(3) states clearly that: 'States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.'<sup>23</sup>

A further declaration that fundamentally applies in the case of FGM is the right to Development.<sup>24</sup> The practice of FGM must be seen in the context of underdevelopment (no access to education or resources, etc.):

"African analysts of development strategies are today constantly urging that the overall deteriorating conditions in which poor women live be made a major focus for change, for unless development affects their lives for the better, traditional practices are unlikely to change" (Dorkenoo 1994, 17).

The Vienna Declaration of the World Conference on Human Rights in 1993 held for the first time that traditional practices such as female circumcision were violations of human rights and more precise, violations of women's and children's rights (World Conference on Human Rights 1993). This position has been adopted by various United Nations health and human rights organizations. In 1992 the International Federation of Gynecology and Obstetrics published a joint statement on female circumcision with the World Health Organization (Female Circumcision 1992), and in 1993 the World Health Assembly, the highest authority of WHO, issued a similar statement (Female Genital

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<sup>23</sup>It has to be noted that in spite of the general wording, preparatory studies prove that its authors had only female circumcision in mind and not male circumcision at all. The debate on the topic of male circumcision can still be considered taboo. (Aldeeb 1994)

<sup>24</sup>Declaration on the Right to Development, 1986, Art. 2'



Mutilation 1993). Both statements condemn the practice of female circumcision as harmful and call for coalitions to abolish it.

### Examples from Western countries

Several Western countries have passed laws for immigrants that make all forms of female circumcision illegal (Sweden 1982; UK 1985; Belgium has incorporated ban; Norway has a hospital alert system; in France FGM can be considered an offense under Art.312-3). If child abuse laws<sup>25</sup> are applied, circumcision is illegal in every European country as well as the US, Australia and many others and specific anti-female circumcision laws are under discussion in many countries. The regulating laws concerning re-infibulation after de-infibulation (for a delivery) are in the process of being discussed<sup>26</sup>

### Examples from Africa

Formal legislation forbidding infibulation<sup>27</sup> has existed in Sudan since 1946.

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<sup>25</sup>Children are unable to give consent regardless of whether the child is consulted before the procedure or not. Parental consent for a procedure that damages rather than preserves a child's health is ethically and legally unacceptable.

<sup>26</sup>It should be ensured that women who request re-infibulation should not suffer ethnic or cultural bias. Making the operation illegal for consenting adult women is problematic, particularly when, as is the case in Europe and the US, sex change operations and cosmetic surgery on the genitals and other parts of the body are allowed for reasons other than medical ones. Any body change operation might be based on ideas of being conformist or non-conformist to societal ideas or partner demands, rather than sound and independent personal decision-making. True informed and individually grounded choice will only be possible if women's economic and social power equals men's.

<sup>27</sup>It is not an offense though (Art. 284, Sudan Penal Code for 1974) 'merely to remove the free and projecting part of the clitoris' (Dorkenoo 1994).





Egypt's Minister of Health signed a resolution in 1959, recommending only partial clitoridectomy for those who want an operation, which is to be performed only by a doctor (Assaad 1979).

Somalia's Women's Democratic Organization proposed a bill in 1978 to 'competent authorities' to eradicate all forms of FGM. Kenya took steps to ban the practice in 1982; any circumciser found to be carrying out the operation can be arrested and brought before the law. Burkina Faso's and Senegal's heads of state, made official declarations against FGM.



## 2.9. The Debate around the Involvement of Health Professionals

In 1982, WHO issued a statement that female circumcision should never be carried out by professional medical staff in any setting. This was renewed in 1989 when the Regional Committee of WHO for Africa passed a resolution urging the participating governments: "...to adopt appropriate policies and strategies in order to eradicate female circumcision; and to forbid medicalization of female circumcision and to discourage health professionals from performing such surgery" (WHO 1989). On a recent meeting in 1995, WHO again strongly condemned the medicalization of FGM (WHO 1995). In 1987, the Inter-African Committee (IAC) requested a law that should provide an especially severe punishment for health professionals (IAC 1987).

The main area of concern for health practitioners is the danger that a trained and licensed practitioner could be expected to assist in circumcising a girl<sup>28</sup> It is widely felt that there is a great danger in treating the issue purely as a health one, which is the tendency to 'clean up' the gore aspects of the operations by either offering to perform them in hospitals, or by providing midwives and other operators with anaesthetic and penicillin.

"Indeed, thousands of health kits issued by international health organizations have been used for just this purpose - 'sanitizing' the custom, and thus effectively removing some of the health-based objections. The temptation to reduce pain and death by offering to do the operations in hospitals 'in the meantime' must be refused" (Dorkenoo 1994, 15).

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<sup>28</sup>Another main topic evolving for the health professions is the question of how to deliver the most appropriate clinical care and psychological support to girls and women who have already suffered from this practice.



Statements like these are given by NGOs<sup>29</sup> as well as funding agencies, international organizations, African Committee's and the various UN agencies (UNICEF, WHO, UNFPA); they all dismiss the possibility as ethically wrong; it rests on basic ethics of health care where unnecessary body mutilation can not be condoned by health providers and medicalization does not eliminate the fundamental harm.

"...there is now evidence that economic pressure and lack of clear regulations by professional bodies have enticed some physicians into the lucrative market of 'safe' female circumcision. These health professionals are basing their actions on the belief that 'safe' female circumcision is a preferable alternative to unsafe traditional practices. It is critical the UNICEF, together with WHO and other international organizations, work with international and national associations of physicians and nurses to regulate and monitor their members to prevent them from performing FGM" (UNICEF Directive 1994).

A further danger is that if circumcision is performed within the health care setting, it would add to a new legitimacy to excision. A serious effect could be the possible loss of trust and confidence in those that are the caregivers.

"It is of course true that the conditions can be improved (anesthesia, hygiene, sterilization material...) but indirect support can be perceived as an approval of the practice. The use of anesthesia can also increase the impact of the operation since it will be easier for the person to execute it" (MSF 1994).

Medecins sans Frontieres (MSF) one of the leading non-governmental organizations in the field of international medical relief work suggests to their staff an approach of 'passive resistance'.

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<sup>29</sup>Non-governmental organizations



"Never perform female circumcision yourself. Never facilitate female circumcision by any means, nor by giving equipment, nor drugs, nor training in the techniques. Don't give injectable drugs to Traditional Birth Attendants. Never hand out minor surgical equipment to them, unless given appropriate training on sterilization procedures and tight supervision on its use (obstetrics only!). Never allow female circumcision to be performed inside the health infrastructure where you work.." (MSF 1994).

### 2.9.1. Critical arguments in support of a policy change:

\* In spite of the general wording in the 'Convention on the Rights of the Child', preparatory studies prove that its authors had only female circumcision in mind and not male circumcision at all (Aldeeb 1994). In accordance to the wording of the 'Convention on the Rights of the Child' the distinction between female and male circumcision cannot be acknowledged as both are bodily mutilations, involving the unnecessary cutting on a healthy organ and consequently causing damage to the physical integrity of the child. Despite this fact, male circumcision does, in most cases, take place in health care settings and is performed by professionally trained medical personnel. Physicians who practice male circumcision are guaranteed medical immunity.

"One must reiterate that a distinction is wrongfully made at the medical and intellectual level between male circumcision, which is generally accepted, and female circumcision. Neither the WHO nor the Inter-African Committee, nor UNICEF, nor the London Declaration [first conference on FGM in the Western World in 1992], nor the Western laws forbidding female circumcision make any mention of male circumcision" (Aldeeb 1994).

Scientifically, it can be argued for and against male circumcision. Arguments in favor generally highlight its positive and beneficial effects in terms of hygiene and reduced





disease transmission (even HIV) from man to woman during intercourse. Arguments against are based on the unnecessary danger to which the male child is subjected, as the beneficial effects claimed have to be scientifically denied (Zwang 1989 in: Aldeeb 1994).

\* A widely neglected issue related to this context is the drawing of a distinction among different forms of female circumcision, in as much as minimal female circumcision can be compared to male circumcision. What counts eventually is whether the performance is intended as a contribution to the goal of ending any form of mutilation towards children. In fact, in the case of professionally done 'sunnah' circumcision, where only the skin on top of the clitoris is pierced in order to cause some ritual bleeding, medically speaking less mutilation is involved than in male circumcision which requires the cutting of skin. Male circumcision is legally performed by health care professionals in many countries, even in hospitals of the Western Nations. The Netherlands, who wanted such a distinction made, were vetoed by WHO. The reason given was that WHO felt it would be impossible to control the practice if one permitted one particular form of female circumcision and punished others (Dr.Mehra/WHO in: Aldeeb 1994).

This firm attitude opposing distinctions between the various forms of circumcision is not shared by Muslim law. The latter makes a distinction between the permitted female circumcision called 'sunnah', while other forms, though widely practiced, are condemned by religious circles. This distinction also applies in Muslim countries.

\* Despite the above statements and many resolutions made by professional bodies



against female mutilation, it was reported in a UN Human Rights Seminar on Traditional Practices, held in Burkina Faso in May 1991, that medical personnel seem to continuously replace midwives and traditional circumciser's and are conducting circumcisions in hospitals. There is an increasing interest on the side of the hospitals due to economic/financial gains (Dorkenoo 1994; Aldeeb 1994). Likewise, two other studies, prepared for WHO seminars on traditional practices, found that a high percentage of circumcisions were performed by physicians, traditional birth attendants, midwives and nurses (Armstrong 1991, 42).

Medicalization of female circumcision is, in fact, increasingly practiced among the urban intellectual elite of some African countries and in some European hospitals (Vernier 1990 in: Aldeeb 1994). Family members of the well-off and educated classes have the 'privilege' of being able to afford a safe, pain free operation, performed by a medically-trained person (Guenttner 1995).

\* It has been shown that radical legal prohibitions against FGM will only encourage female circumcision to go underground. It will then be performed by persons without proper knowledge thus endangering the woman's health.



## 2.10. UN Agencies and their Approach

UNICEF, WHO and UNFPA have commonly stated in 1995:

"While the international community is committed to respecting cultural differences, it is vital that a clear and unambiguous message is sent that this particular practice is universally unacceptable because it is an infringement on the physical and psycho-sexual integrity of women and girls and it is a form of violence against them" (Joint Statement 1995, 2).

UNICEF justifies its activist role against female genital mutilation through the resolutions found in the 'Convention on the Rights of the Child (CRC)', the 'Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)' and in the 1990 World Summit for Children (WSC) Declaration and goals for the year 2000.

To reach their goal of ending the practice of FGM, UNICEF country offices have formed partnerships with non-governmental organizations (NGOs) and support projects which aim to eliminate FGM, primarily through education, training and advocacy (UNICEF Directive 1994). A strong focus is on UNICEF's role as an advocate on several levels: government, NGO's, the media, health workers and community leaders. Support should be given to:

- women's and youth NGOs for fostering information exchange and young ideas;
- religious leaders as their stance on this issue is critical within the community;
- parliamentarians and legal groups to advocate for legislation outlawing all forms of FGM;
- working with media on information and communication campaigns (discussion programs, films, radio, plays, puppet shows, story telling, etc.);



- creation of regional and sub-regional networks (advisory and monitoring roles, sharing success and lessons learned);
- doctors, nurses, midwives and other health care providers whose practice and opinion on health issues sets the standard in many communities.

The Joint WHO, UNICEF, UNFPA Policy Statement further suggests many diverse international, national and community actions such as: research needs, policy development, networking and collaboration (especially with action-oriented NGOs), education, integration into existing health programs, issues of sustainability, use of mass communication, post-FGM treatment, targeting of special groups, etc. (Joint Statement 1995, 7,8,9). These UN agencies aim for a major decline of the practice in ten years and a total eradication within three generations. Each agency will focus on its area of expertise but complement others in their common action. WHO will establish a centralized database on FGM, disseminate information on the epidemiology and take a special responsibility in the training of health care workers. UNICEF centers on providing support to community-based organizations engaged in information, education, communication (IEC) and training activities on FGM. UNFPA will mainly continue to advocate for the eradication in all areas of the world and will support the revision of national policies, laws and regulations. It was further proposed and agreed in 1995, that an International Forum on FGM be established to promote and support the development of country-oriented programs within the broader context of girls' and women's health and human rights.





## 2.11. The National Committee on Traditional Practices

At a conference in Dakar in 1984 on "traditional practices affecting the health of women and children" (financed by WHO and UNICEF) African and Arab women finally began to effectively shape the style of the campaign against circumcision. Delegates agreed that national committees should be established within each country where female circumcision is practiced. They subsequently set up the Inter-African Committee (IAC) - a non-governmental organization working to promote the health of women and children in Africa by fighting harmful and promoting beneficial traditional practices - to act as a bridge between the local groups and outside supporters who fund the work. The IAC is headquartered in Addis Abeba, Ethiopia. In 1995, the IAC was granted official status by the World Health Organization. Since 1985, National Committees have been set up in 24 African countries.

The National Committee on Traditional Practices in Ethiopia (NCTPE) was established in 1985. Initially working under the umbrella of the Ministry of Health, the NCTPE obtained legal NGO status in 1993. It is now a non-governmental, non-political and non-profit making organization officially registered with the Ministry of Internal Affairs and affiliated with the Ministry of Health and has been supported by both Ministries with regard to office space, equipment, transportation and staff assistance.

The objectives of the NCTPE are:



- to promote and encourage traditional practices that have positive effects on the health and psycho-social well-being of the society in general but for women and children in particular. These include: breast-feeding; caring for the elderly, the sick, the disabled and orphans within the family circle; caring for women who newly delivered; sharing happiness and sorrow with relatives and friends; and discussing problems and solutions in woman's organizations.
- to discourage and eliminate harmful practices, mainly FGM, but also tribal marks, uvula cutting, tooth extraction and other practices that are detrimental to the health and well-being of the society, but especially to the health and well-being of women and children.

#### The NCTPE's statement towards Female Genital Mutilation:

"Female Genital Mutilation is the most widespread form of torture in the world. It is also one of the most painful. At least 80 million living African girls and women are victims of this traumas. This practice is not sanctified by any religion. Deep rooted traditions like this can lead to a situation where women are still treated as inferior partners in life. We are trying to raise awareness, we believe in sensitizing the different target groups in the country and to this end we organized training of trainers, and training and information camps. Seminars and workshops were conducted throughout the country. We start on the national level, go on to the grass-roots and sensitize the people down there, until eventually the fight against female circumcision becomes a mass-movement" (Modernizing Tradition, 1993).

#### The NCTPE's Strategy:

The main strategies to achieve the NCTPE's goals consist of effective and intensive



information and education campaigns among the different target groups. As part of the campaigns, the Committee conducts seminars, workshops, TOT (Training of Trainers) and TIC (Training Information Campaigns) activities. The Training of Trainers and the Training Information Campaigns are recommendations suggested in 1987, at a Regional Seminar in Addis under the auspices of the Inter-African Committee (IAC) and play a big role in the NCTPE's activities. The general idea of TOT is to train representatives from Regional Health Departments in order to create regional working groups, by providing them with the necessary skills to design, organize and conduct training and sensitization activities related to the campaign to eradicate FGM and to organize and conduct TIC's on the district and local level. It is therefore an important part of the strategy to properly select the target groups to participate in the different TIC training sessions. They must have an adequate background, enough experience to benefit highly from the program and a high enough position to ensure the enhancement of the plan of action once back in their communities. Examples are: health workers from the Ministry of Health, teachers from the Ministry of Education, extension workers from the Ministry of Agriculture and mass media professionals from the Ministry of Information.

The criteria for target group selection include that they have a large constituency and ability to influence people and a high status in the community<sup>30</sup> It therefore focused on: community leaders, religious leaders (Muslim and Christian), traditional healers, health workers, TBA's, administrative personnel from the districts, extension agents from the Ministry of Agriculture, and women and youth groups.

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<sup>30</sup>Educational background was not considered necessary for selection.



Other strategies of the NCTPE include reaching such people as artists, singers and actors and providing them with information on FGM. These groups are thought to be able to influence large numbers of people and often constitute role-models for the young.

Mass media coverage is also important to the NCTPE's work. Continuous contacts with people involved in mass media are a regular part of the work of the Executive Committee members.

Further, the NCTPE tries to reach young students through special programs, as it proves easier for the adolescent to change their attitudes and behaviors. Until recently, the programs conducted have been short and reached about 1200 students. Youngsters were provided with information about FGM and other harmful traditional practices using various methods such as drama, lectures and video shows. The NCTPE also conducted a pre- and post evaluation of its teaching methods and the level of sensitization of the students.

Further relevant teaching aids, such as posters<sup>31</sup>, leaflets, video-films, T-shirts, etc., are produced to enhance the campaigns.

NCTPE also publishes a quarterly Newsletter to diffuse relevant information on harmful traditional practices, to give up-to-date insight into their progress and activities, to facilitate communication and to serve as an open forum for the expression of opinions.

Due to a continuous effort to encourage the development of research on FGM, the

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<sup>31</sup>Posters and education material are presented in a very ethno-sensitive way. There are various posters against FGM, whereby the people represented would suit the taste of different ethnic groups in style of clothing, facial expression. There are also constant evaluations ongoing about how people feel toward these visual educational media.





progress of the work done so far and to assess research needs, the following studies were accomplished in 1994: perception and attitude of different tribal and religious groups towards FGM; complications of FGM during labor; knowledge and attitude of policy (decision) makers; focus group discussion in antenatal clinic with pregnant women; and intervention in high-schools.

NCTPE was represented at the Fifth Regional Conference on Women held in Dakar, Senegal 1994, at the International Conference on Population and Development in Cairo Egypt 1994, and took actively part in the Fourth World Conference on Women in Beijing, China 1995.



## 2.12. Law and the Status of Women in Ethiopia

Daniel Haile, assistant professor of the faculty of Law, Addis Ababa University, remarks in 1980:

"Female circumcision is another phenomenon which is not only closely related to the health of women, but is an item which again reflects the double standing of some of the prevalent attitudes and values in Ethiopia. Female circumcision is widely practiced in Ethiopia. All girls are circumcised throughout the highlands with the exception of Gojjam....Female circumcision thus, first and foremost, is a danger to the life and health of female children...and it reduces the sensitivity in the genital area of women. Moreover, Penal Code Arts. 537, 538 which includes the maiming and disabling of essential organs would by interpretation cover female circumcision and make it illegal. However, as in many other matters even though it is the legislator who proposes, it is the people who dispose and such laws are not implemented"

The Transitional Government of Ethiopia issued a 'National Policy on Ethiopian Women' in 1993. The new policy tries to address issues such as inequality and gender-bias in terms of working conditions in the formal as well as the informal sector; rural/urban disparities; social issues; health conditions; education; laws prejudicial to women like land inheritance, citizenship, retirement benefits, etc., and harmful customs and practices.

"That Ethiopian women are victims of circumcision and other harmful practices that come with child-birth is also common. We also know that these practices contribute to women's dying while in labor. Such harmful customs and practices must be eliminated, for they stand in the way of progress and endanger lives. They should not be allowed to perpetuate. Both men and women have to be made aware of these harmful practices at all available forms, especially in the classroom" (National Policy 1993, 18).

Similar to this statement, the new policy in Ethiopia tries to define objectives and present implementation strategies, like the establishment of a women's affairs sector in the



prime ministers office. The 1995 election constitutes the first democratically elected government since the period of transition. It might be too early to analyze the impact of its work.



## **THE STUDY**

### **3. Methods**

#### **3.1. Design and Purpose**

A qualitative descriptive study design was chosen to examine the perceptions, beliefs and attitudes of health workers and people from the community towards female infibulation. The study's specific objective was two-fold: 1) to evaluate the readiness and willingness of the local Somali population in Jijiga town towards ending this traditional practice; and, 2) to identify obstacles in doing so as well as practical indigenous ideas for action. To achieve this, I conducted a focused ethnography to collect participant's ideas and experiences. The primary source of the study, infibulated local women and men married to infibulated women from the community, provided personal, realistic and contemporary insights into their own and the communal perception concerning the cultural tradition of female infibulation and the possible ways for change.

#### **3.2. Site**

The study was conducted independently by myself and occurred in two parts. The first cluster of interviews were held during the months of July and August 1995 at two different locations: 1) in the town of Jijiga, Somali National State; and 2) in Addis Abeba,





the capital of Ethiopia. The second cluster of interviews were done solely in the town of Jijiga during the month of January 1996.

### 3.2.1. Population and Health Data

It can be assumed that any collected data about the Ethiopian population during the nineteen-seventies, -eighties and -nineties were skewed by war and famine related deaths and morbidity. The combined effects of severe droughts, overgrazing, deforestation<sup>32</sup>, poor agricultural practices, a 17-year civil war and continuing political change have greatly affected Ethiopia's environment and people. Somali National State, because of its common border to Somalia and its drought stricken lowlands was challenged especially hard. Since 1984 Ethiopia suffered two devastating droughts and as a result major famines. An international relief effort in 1985 brought in 900.000 tons of food but one million people died during the famine and many more fell ill (Worldmark 1995). This food aid was continued on a reduced scale and the government launched a massive resettlement program in the years after. The drought and resulting famine of 1991 again affected a great number of people (8.7 million). At the end of 1992 Ethiopia was harboring 406,100 Somali refugees in camps along the border, mainly in Somali National State. From the mid-seventies up to the year 1991 an estimated 8,3 million people had been internally displaced or were forcibly resettled within the country, because of civil strives, border fighting and droughts. Between 1974 and 1992, there were 575,000 war related deaths (Worldmark 1995). These events impacted the social

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<sup>32</sup>340 square mile loss per year



structure of the communities in many ways.<sup>33</sup>

Until today an effective health information system is not in place and only a few selected surveys have been carried out over the last years, none of which were comprehensive or large in scale (Barnabas 1995; Mammo 1993; Materia 1993). These studies all state a lack of information on population dynamics, the need to collect baseline indicators, the need to collect ecologic data and the need for further executions of pilot studies.

Jijiga town is the 'capital' of Jijiga zone, one of the nine zones that form Ethiopia's Somali National State (see map in App.A, Fig.2). Jijiga is situated in close approximation to the Somali border and therefore to the major Somali refugee camps in Hartasheik (see App.A, Fig.1) The first and only comprehensive population census ever done in Somali National State was in 1984 (Population Census 1984). The state was then called Hararge Region and the alignment of the boundaries was running slightly different. However, the 1984 census could only cover 64 percent of the population of Hararge region, it could not include the low-lands with the nomadic population, which account for 36 percent of the entire population. This implies that the population that was not covered is living a nomadic life in remote rural areas, with little or no technical infrastructure (electricity,

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<sup>33</sup>One example is the increasing number of single female-headed households in Somali National State. For these families numerous health implications have to be considered: children are at increased risk of malnutrition; the income patterns change as women are not able to continue agricultural work with draft animals, they often do not have adequate agricultural knowledge, tools, seeds, accessibility to credit schemes, alternative sources of income generation ; it is difficult for the women to sell their farming products in the market (no means of transportation, no safe and sheltered market place) and these women have the double burden of financially supporting and caring for their families (Materia 1993; Priority assessment 1995).



roads, buildings, etc.); that their socio-economic and educational status is probably lower than that of the censured population; equally their access to professional health care, proper sanitational facilities and pure water is even more limited than for the recorded group<sup>34</sup>

### 3.3. Subjects

With the help of two local co-workers and friends, both fluent in English and Somali, I conducted 12 semi-structured interviews with a total of 69 participants (20 men, 49 women). Of these interviews:

- five were with male and female professional healthworkers from the Jijiga community;
- one was with a group of Somali women elders in Jijiga town;
- four interviews were designed as focus groups in Jijiga town:
  - two with women (on one occasion there were 40\*, on another eight participants)
  - two with men (on one occasion there were six, on another five male participants);<sup>35</sup>
- two were with members from the National Committee on Traditional Practices in Addis Abeba.

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<sup>34</sup>See App.B for a detailed analysis of the data.

<sup>35</sup>All subjects of the focus groups were members of the local community, except the participants in the big focus group (\*), who were a composition of women representatives of the 9 different administrative zones in Somali National State).



The ages of the study participants ranged from 17 to 60 years. Their educational status ranged from no schooling and illiteracy to college graduates. Over 97 percent of subjects were married. All participants were either infibulated or married to infibulated partners.

### **3.4. Recruitment**

Participants were recruited through three different strategies: (1) purposive sampling of a range of key informants like professional health workers and influential elders from the community as well as members of the National Committee; (2) convenience sampling of former co-workers who belonged to the Somali tribe and were infibulated; and, (3) snow-ball sampling through the personal contacts of early study participants. It was a purposive choice to recruit highly educated social and religious leaders and official members of the National Committee. Snow ball sampling was achieved by the help of key people in the community who contacted men and women's group elders and arranged the focus groups. These groups provided a wide spectrum of participants from members of the local communities and female participants representing all 9 regional zones of Somali National State. The interviewees agreed that no monetary compensation would be given for the interviews.

### **3.5. Instrument**





A semi-structured interview schedule was drafted explicitly for health professionals and members of the National Committee in summer 1995, during my internship. It included questions about: the prevalence of infibulation; the reasons for its persistence; appropriate interventions; community involvement in change; and organizational considerations.

Coincidentally, following a one-on-one interview, I was invited to participate in a group meeting of local and other zonal women representatives. Based on this experience and a first evaluation of the research findings in New Haven, it became obvious that further research focused on the perception and knowledge of the men and women in the local community would yield promising results.

The research tool was therefore further sharpened and partly redesigned as a specific open-ended questionnaire for women (1) and for men (2). A second round of interviews was conducted in January 1996.

1) The women's interview schedule collected information about:

- prevalence of infibulation
- personal memories of the operation
- cultural reasons for circumcision
- physical complications
- reasons for change of perception
- suggested interventions in order to change or replace the custom.



2) The men's questionnaire asked about:

- experience of being married to an infibulated woman
- having seen or attended an operation
- medical complications of female relatives
- attitude towards traditional practice and reasons for persistence
- reasons for change of perception
- suggested interventions in order to change or replace the custom.

### **3.6. Data Collection**

All interviews were entirely voluntary and were done only after receiving oral informed consent. Interviews were not recorded as the translation procedure left sufficient time for complete note taking by the author. Further, electronic media (like tape recorder) were not used in order to not interfere with the intimate bond of women talking to women in seclusion. Assurances were given to the participants that their names would not be recorded, that their identities and participation would be kept strictly confidential and that they would not in any way be linked to the information on the transcripts.

Interviews were conducted at the following locations: the regional health bureau of the Ministry of Health in Jijiga; the women's group meeting place in Jijiga; two of the men's homes in Jijiga; the local hospital in Jijiga; the National Committee on Traditional Practice offices in Jijiga (UNHCR-building); and Addis Abeba.

An elder from one of the local women's groups and a group member of the local



men's group helped in the translation (Somali to English) of the 4 focus groups conducted in the community. The other eight interviews were carried out solely by the myself in English.

Even though the printed sheet of questions served as a guideline during the interviews, because of the very personal nature of the subject, the majority of questions were asked from memory and related to the specific atmosphere of the group and its participants' individual openness and degree of awareness. This approach gave great flexibility in asking follow-up questions and exploring unexpected themes as the conversations progressed. Interviews varied in length, according to the number of people present from 20 minutes to more than two hours.

### **3.7. Other Data**

The research was initiated through a personal oral history of becoming aware, as I had the opportunity to participate in a priority assessment on the needs of Somali Returnee women of Somali National State in summer 1995. It led me to visit rural villages and brought me into close contact with a number of infibulated women living under difficult conditions in remote communities. The team stayed out several nights and days on each field trip and close contact was easily established as in Somali culture women spend their evening hours socializing amongst each other, secluded from men. During these occasions I gained the first crucial insights into the complexity of the topic. As I became friends with the women and men of the team, the issue of acceptance in the



communities and also within the community of Jijiga town upon return was almost entirely resolved. The opportunity to return in January 1996 to already established personal relationships and a reputation helped tremendously.

In fact, there was a dual advantage. First, being an outsider helped especially the men in the community to talk openly about an issue that they might not consider mentioning towards women of their own culture. Second, having already established a familiarity with key people and being a woman, allowed me to gain a deep level of insight as the participants had no barrier to emotionally open up.

Information from a number of other sources was used to further understand the data collected from the primary sources. During my stay in Jijiga, I visited patients and talked to nurses in the gynecological ward of the local hospital as well as the local Maternal Child Health Clinic. I also paid several visits to the National Committee on Traditional Practices and the Inter-African Committee in Addis Abeba.

### **3.8. Analysis**

Information gathered from the interviews was grouped into themes with the objective of constructing a focused ethnography on the cultural practice of female infibulation and its possible change. Content analysis was done upon return to New Haven. The transcripts, observations and reflections about ideas, attitudes and beliefs in the text, as recounted by the participants, were coded, i.e. given major headings. Text





with similar codes was examined and compared across interviews, leading to the identification of several major themes. Emphasis was placed on understanding the main patterns of cultural belief concerning the practice of infibulation and the indicators for possible changes in perceptions as suggested by the subjects. Also, comments discordant with dominant themes were identified and examined. The final product is a synthesis of present leading attitudes and principal suggestions for change.

### **3.9. Strengths and Limitations of Data**

Focused ethnography was chosen as it has proven helpful in understanding the differences between various cultures and systems of meaning (Agar 1986). Techniques such as participant observation and in-depth interviewing were meant to generate rather than test hypotheses. This community approach is an important focus as most intervention strategies are planned by people from one 'system of meaning', mainly the West, and are applied to people from other systems of meaning and without sufficient cultural knowledge.

The easily recognizable strength of these qualitative data is its ability to describe deep personal experiences and emotions. Especially as infibulation deals with physical, mental and psychological aspects of health and well-being of the concerned women and also the men, a qualitative design seemed most appropriate. It helps to enlighten the meaning of an old traditional practice which is deeply embedded in a cultural value system and truly allows one to form a non-judgemental attitude of understanding. It also presents



a chance to learn how to deal with goals of global health promotion that conflict with present indigenous traditions.

The advantages of this research strategy are probably at the same time its major limitations. Due to the fact that very personal feelings and perceptions were expressed by the participants, its generalizability to other communities, especially outside the traditional Somali culture is likely to be limited. But even within the Somali communities in Somali National State of Ethiopia, the prevailing perspective of this study can probably be seen as a very 'modern' one, which might not be shared by a majority. However, the informants in this study are not atypical, but the full range or diversity of Somali views on the matter is certainly not represented. This possible bias comes to mind as the interviewed subjects represent a group that predominantly had gone through a process of awareness change, as the findings show. About 25 percent of participants were literate and about 10 percent had some knowledge of English. As Jijiga town is closely located to one of the major refugee camps along the Somali border, a number of NGOs as well as UNHCR and other aid and relief organizations are stationed in the area. Therefore it can be assumed that most people in the community, including some of the participants, had exposure to Western ideas and ways of life in one way or another.



## 4. Findings of the study

### 4.1. The Prevalence of infibulation

Infibulation seems to be the most prevalent form of female genital mutilation among the Somali population in Somali National State in Ethiopia. The estimated prevalence of infibulation among women is higher than 99 percent.

Infibulation, the most severe type of circumcision, seems to be the most prevalent form of female genital mutilation at present among the Somali population in the Somali National State (Region 5). All respondents, health professionals, members of the NCTPE<sup>36</sup>, as well as women and men from the community, estimated an infibulation prevalence of more than 99 percent in women. Most people interviewed in Jijiga stated that they do not know any uncircumcised Somali woman in the community and that all their female family members are circumcised. [1,2,4,5,8,10,11,12]

### 4.2. Facts about the tradition

Most girls are between 6-11 years of age when infibulation is performed. The majority of women remember the event as a painful, helpless, yet awaited moment in their lives. Often two to four girls are circumcised on the same occasion, which takes place at their home. Symbolic rituals (like gathering of women, breaking eggs, slaughtering a hen, offering of popcorn, etc.) and the infibulation 'technique' itself seem to have remained the same over time.

The majority of the girls are 6-11 years old when circumcision is performed. In

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<sup>36</sup>National Committee on Traditional Practices of Ethiopia



this age-group conscious awareness is already high, which is shown in the fact that all interviewed women had a rather vivid memory of the events that took place when they were circumcised. Most of their descriptions center around the fact that they were not helped by anybody and that they could not help themselves.

*"I can remember the pain - you are so powerless, the older people hold your body down. There is nothing you can do".[11]* (infibulated Somali woman)

*"I remember my circumcision very well. I was already 11 years old when it happened. I don't know why I came to be circumcised so late. I guess it was my grandmothers decision eventually when I came to visit her. I remember how much I struggled and tried to run away when I realized what would happen to me. I must have been strong, as it took many women to hold me down. The pain was incredible, I cried for my mother, but she was not there to help me. Yes, I remember well, every moment of it. I never forgot. I don't think any woman can".[13]* (infibulated woman, literate)

Other impressions are that this was a very special day, which they had awaited with hesitation but also with impatience.

*"When I came here [Jijiga] I realized that the girls are told it is a good thing to be closed and they look forward to it happening to them. I was still small...but I wanted to be done like them. When I came here I realized that the girls are told it is a good thing to be closed and they look forward to it happening to them. I have seen girls running to the shop to buy a razor blade in order to be cut as well. The little girls are still influenced in the same way today, I can hear them talking when I walk in the streets".[11]* (infibulated Somali woman who only 'sunnah'<sup>37</sup> circumcised her daughter)

The symbolic rituals that surround the operation and the actual performance of

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<sup>37</sup>Sunnah circumcision does not involve any cutting, but the piercing of the skin on top of the clitoris in order to cause some ritual bleeding (see chapter 2.3.)





infibulation, as reported to me, are very similar to those reported in most anthropologic or other scientific studies<sup>38</sup> and filmed documentaries in Jijiga town<sup>39</sup> Therefore the following quotations just give a short insight into the original ceremony.

*"The girls are about 8 to 10 years old. They always take two or three of them together. Men are not allowed to watch or attend the ceremony, only women from the community are present. The circumcision takes place in the morning hours. They serve tea and coffee, and the atmosphere seems excited and joyful. The women will break eggs in order to scare the devil away and fill bowls with popcorn for the girls to eat and as a good sign".[5]* (Somali man, highly educated)

Another description by a health worker of the National Committee sums up his collected experience from interviews to women.

*"Early in the morning the female relatives gather around the house where the girl lives. There is always an egg that will eventually be crushed. It stands for the future fertility of the "little bride" and is used to cool the open wound after cutting. A hen is slaughtered just before the ceremony, and the "eye-mother" puts her hand on the girls eyes during the cutting. The circumciser brings acacia thorns along for the final stitching of the wound".[6]*

After the infibulation the girl gets dressed in her new cloth, her legs are bound

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<sup>38</sup>See David's (1987) description of an infibulation in chapter 2.3.1.

<sup>39</sup>Video documentaries: "Belief and Misbelief" (Inter-African Committee; I have a personal video copy); "Infibulation"(filmed in Jijiga town by NCTPE, 1994, personal copy); and "The Infibulation of Girls"(filmed in Jijiga town, ZDF-German TV documentary, 1992, personal copy). I have, for various reasons, including ethical and cultural ones and considering the fact that there are very good documentaries available, deliberately not attended an infibulation ceremony.



together from her waist down and she lays down to rest. At times there will be a hole in the ground that releases warm incense smoke that is believed to speed up the healing process and dry up the wound. For up to 40 days the girls are kept under close supervision, often with certain dietary and behavioral restrictions. The first few days are especially important in order to avoid future complications; therefore girls are only offered a little bit to drink and eat, as to reduce defecation and urination; they are also encouraged to walk slowly and in little steps.

#### 4.3. Who are the circumcisers?

Circumcisers are old women from the community. Their original tribal professions (such as blacksmith and butcher) have to do with slaughtering and cutting animals, activities which are perceived as unclean. Therefore they are considered to hold a low social status in the community. Nevertheless they have an impact on the public opinion on circumcision, as they also visit many houses at times of needed assistance during deliveries, if labor is obstructed and an episiotomy-like procedure has to be performed. As circumcision strongly contributes to their income, they have a vital interest in the persistence of the tradition.

Circumcisers in general are old women who live in the community [1,4]. They seem to originate from a certain tribe which was reported to me in differing names, like "midgo"[1], "hebrew"[4], "goboja"[5]. What they have in common is that they earn their money as blacksmiths, butchers, and producers of metal tools and agricultural instruments; at times they also deal chat (local addictive drug) and make shoes and pottery.

Remarks like "*..they are the ones who take on tasks like slaughtering animals for the community, which is seen as an unclean occupation*,"[1,5] and "*..these are the people*



*who know about cutting and sharp instruments*"[5] were frequently made. Due to performing these unclean jobs, circumcisers are considered to have a low social status in the community: *"they have no shame"*[1]. Nevertheless they are generally financially well off, and circumcision is an attractive additional source of income for them [1]. The community respects them in a distant and special way, as every family will rely on their service at a certain time, not just for circumcision services, but for attending difficult deliveries as well, in case labor is obstructed and an episiotomy-like procedure has to be performed. A Somali nurse said:

*"The circumcision takes place in a girls home. When it is time the circumcising woman is called in a very polite way. At times she has to be invited several times up front and if the family can afford it, they will send a horse-drawn carriage to pick the woman up".*[4]

Circumcisers can expect about the same amount of money for a circumcision as for a delivery, around 50 Birr (about US\$ 9) or a gift of higher/lower value like a goat, a sheep, chicken, depending on the family's wealth.[4,5]

Circumcisers have a strong influence on public opinion. They visit nearly every household. They advocate for circumcision to stay hidden and secret in order to not lose their business. A health worker from the National Committee recites what circumciser tell their clients: *"Who is it that really takes care of you? White doctors are rich people, they take your money, but don't care about you".*[1]



#### 4.4. Reasons why infibulation is performed

The factors that support infibulation are the men's perception of owning his wife and the women's attitude of obedience to her husband. Further, women are seen as being unable to take care of themselves and unable to make responsible decisions about their own sex life. Therefore, parents feel it is their duty to protect their daughter's physical and moral integrity by infibulating them. In addition, the guarantee of the daughter's virginity can affect the livelihood and reputation of the mother. A woman's virginity is, furthermore, associated with a small vaginal opening due to a tight infibulation, which is seen as the proof that penetration has not occurred. The size of her vaginal opening will determine her dowry, her marital status and the family's prestige in the community.

Answers to the question "Do you know why infibulation is performed?" were manifold, but in general all corresponded to earlier mentioned and elsewhere reported research findings<sup>40</sup>. The major arguments were to ensure the girl's virginity as well as to ensure the future husband of his bride's virginity; and to protect her from promiscuity and her own overwhelming sexual interest (before marriage as well as later in life to prevent her committing adultery); to raise her marital status, including the dowry; to obey to an age-old tradition and to dedicate the girl to Allah; to ensure the men's superior role; to protect the family from shame and loss of status. As the following quotes will demonstrate, even professionally trained medical personnel do not seem to be able to part from traditional views when it concerns their own daughters.

Interestingly, virginity is associated with a small external vaginal opening which is achieved by a severe infibulation. If the girl is still tightly sown up around the time of marriage, she is thought to not have had sexual intercourse and therefore is still a virgin.

The man's perception of owning his wife and the woman's attitude of obedience to

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<sup>40</sup>See chapter 2.6. for 'Cultural Meaning'





him is often seen as one of the major factors that allow female circumcision to be so prevalent. A health worker for the NCTPE explains:

*"Men in our culture prefer virgins and see women as a possession. For him, it is like owning a tool, a car, a chair. Women view themselves as a property of the man, as a gift, as a flower. They feel subordinate, can't speak out and can never tell him their feelings. A divorced woman has only seldom a chance to marry again and so they patiently carry their suffering. You can see this in how the circumcision is done. It is meant to bring satisfaction to the man - sometimes even the size of her vagina is made to fit his penis". [6]*

The perception that women are the possession of their husbands can result in extreme measures, as a Somali midwife experienced:

*"Let me tell you a story from Yemen where I worked as a nurse in the hospital. One day a Sudanese man with his wife came to our gynecology department and said: 'I want my wife to be re-infibulated because I am going away for two month and I want my door closed.' What do you think, I nearly lost my job because I didn't want to do it. The owner of the hospital found another nurse who would do the job and sure enough, two months later, when the husband of this woman returned, she was opened-up again". [9]*

Women in general are seen as not being able to take care of their own sexual life and unable to make responsible decisions; they need to be protected against others and themselves. I was asked frequently how I could keep my life in control, even though I was not circumcised. A health worker quoting his clients said that the following arguments were mentioned most frequently: *"...if a door is open - everything can enter"* and *"...if my daughter is not sealed I make her a prostitute"*

A Somali man in favor of infibulation explains how circumcision is viewed as a



'civilized' tradition that evolved over time:

*"Adam was naked when God created him, but then he learned to dress by himself. That was sensible, wasn't it? And in the same way we learned to protect the opening of our women, which is uncovered and unprotected naturally". [10]*

Therefore parents feel that they fulfill an important part of their parental duty and responsibility in protecting their daughter's physical and moral integrity by infibulating her.

A male Somali nurse, working in the gynecological ward and therefore aware of the medical complications that infibulation brings stated:

*"I have four daughters and they are not circumcised yet. They are still too young. When the time comes, I will do it myself. I will cut their clitoris off, as I do not want them to become prostitutes. Somali women are far too hot, they can't handle their sexuality, they will become promiscuous if they are left as nature build them. It is my responsibility to prevent that and to protect their virginity for their husbands". [4]*

Women are thought to be best protected if they are under the supervision of a man; first their father's supervision and later their husband's. The shamefulness that out-of-wedlock intercourse will bring is often estimated to be one of the major reasons why girls should ideally be married at a young age. A Somali midwife recalled:

*"I tell you why I got married so young. When my father died I was left with my mother alone. People in the village got suspicious, they believed that now I would go after men. When I was down at the river, washing my cloth, they would stand beside me and sing: 'The girl without the father, she has a big vagina, she goes after men. Nobody will control her.' I was so ashamed and so sad. Not just we had to cope with my father's death, but also with this embarrassment. I believed that if I got married the shame will be over for me and especially for my mother. I was 15 years old at the time and I was*



*lucky, because my husband was a good man".[9]*

Virginity is associated with a "proper" and very tight infibulation that only leaves a small vaginal opening. In order to comply with this particular demand of the culture, and to avoid shame and status loss, parents go a long way, even endangering their daughters lives. If the bride's virginity is in doubt, she will be divorced right away and the dowry is returned. Therefore, prior to the wedding the female relatives of the bride as well as the future mother in law gather to test the size of the woman's vaginal opening:

*"At the time of the marriage, the mother, the mother-in-law and an independent witness will gather and prove the brides virginity by trying to penetrate her vagina with their small fingers. It should not be possible to penetrate further than their fingernail. A hole as small as a the end of a 'rat's tail' is very desirable".[4] (Male Somali nurse)*

*"When the girl marries, the mother and the mother-in-law and the sister, they come to the house to check whether she is very tight and her opening is small. They use a small corn-kernel or the top of the small finger to test. This is the proof in Somali culture. You check and see. If the small finger fits in the [vaginal] opening, this is already too much. Then the dowry goes down or she can be divorced".[12](Somali woman)*

Even highly educated health professionals feel pressured to conform to this cultural norm in order to avoid status loss in the community:

*"...our whole family would lose its prestige if we don't circumcise our daughters. Our middle daughter might be sent to America for schooling, she might have a chance to escape circumcision, but the ones who stay won't".[5](Somali man, medical doctor)*

One of the women told an interesting story on how the particular community can



influence the parental decision on what type of circumcision is performed on their child:

*"As a small girl I lived in Harrer, and I was only 'sunnah' circumcised [traditional for this community], but then our family moved to Jijiga...During the infibulation you have a lot of blood-loss and you faint. I know, because finally I was pharaohnically<sup>41</sup> circumcised. My family had decided. They thought that if I am not circumcised I will get pregnant soon. So the pressure came from my parents...I have a daughter and she is only 'sunnah' circumcised. My husband accepts that. We won't touch her. I was circumcised twice and it affected me psychologically a lot. My daughter doesn't live with me. She lives in Harrer; this is the sacrifice I make. Nobody knows and I don't tell anybody. If she would come to Jijiga, it would be difficult".[11] (Somali woman who works with the support of the women's group to raise awareness against infibulation)*

The following statement drastically shows how much a "good" infibulation is experienced as a parental duty:

*"You have no idea how important it is to have a proper circumcision. I will tell you a story about this woman who took part in one of our sensitizing workshops. The mother was in tears when she told me the following story: You know people make the 'kernel-test'. They hold the little corn fruit to the vaginal opening, and if it is not covered with skin all around, the woman will be circumcised again to try and close her opening more. I did it four times to my daughter. The hole was still too big after that. The circumciser said that doing it another time will endanger my daughter's life, but I did not listen. Who will marry my daughter like this? I thought better she is dead than we all have to experience the shame of the community. When we did it for the fourth time my daughter could not move any more. All the skin was expanded and cut around her vagina. She could walk only small steps until she married and was re-opened".[9] (Female healthprofessional, works to inform women about the harmful side effects of infibulation)*

Female respondents frequently expressed that the "quality" of the daughters infibulation (size of the vaginal opening) stands in direct relation to the mother's reputation. In infibulating her daughter she 1) exercises her most important motherly

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<sup>41</sup>Pharaohnic circumcision is the local expression for infibulation





duty, which is to prevent the girl from getting penetrated before marriage; and, 2) protects her own marriage and well-being.

*"Also the girl's mother has an existential interest in her daughters circumcision. In case the daughter gets penetrated or pregnant before being married, the mother will have to leave the home - it is her duty to watch the girl".<sup>42</sup>[4]*

#### 4.5. How changes of perception came about in women

Morbidity due to infibulation in women is high (88 percent suffer frequent pain; 30-40 percent of hospital admissions are accountable to infibulation-related diseases solely), and physical and psychological illnesses are numerous. Most women in the community are familiar with these complications and are able to explain and name different symptoms in Somali language. The crucial change of perception towards the practice of infibulation, however, almost exclusively occurred when at some point in their lives they started to associate their physical illness with their infibulation and stopped thinking of it as a normal woman's disease. Doctors and health professionals, through diagnosing the cause of their pain, seem to play an essential role in the individual awareness process. The final trigger for active change in women can be related to the understanding of the religious teachings (as stated in the Koran).

Most of the interviewed women had outstanding personal histories of bodily suffering. In one of the big focus-groups, where 40 women were present, 35 (~88 percent) declared that they experienced physical pain of one sort or another since their

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<sup>42</sup>The same respondent gives a drastic statement of the consequences of out-of-marriage intercourse: "The Koran knows only two ways to save the soul of a woman who gets pregnant without being married, either she has to be killed five years after childbirth (not during her pregnancy or during the child's infancy, as the child is a pure soul and had done nothing wrong) or the man must marry her, make the child legitimate and divorce her later. If he already has one wife, he has to make sure to provide an equal living standard for both of them. The punishment for a man who makes love to a woman he is not married to is 100 strokes on his body, done by the men's group in the community; if he survives (it is not allowed to beat his neck and head as it increases the likelihood of death) he is free".[4]



infibulation. The director of the local hospital in Jijiga town estimated that 30-40% of the admitted female patients are treated for illnesses explicitly related to their infibulations. Official members of the Regional Health Bureau in Jijiga reported their last survey, which showed that 57 out of 150 women suffered medical problems, which corresponds to the hospital's estimate of approx. 38 percent.[8] These are mainly urinary tract infections, clitoral cysto cells, sepsis, infertility (due to blocked fallopian tubes and clotted blood in the uterus), obstructed labor, painful periods, urine retraction due to blocked urethral meatus, anemia, vaginal fistulas, hemorrhage, death (hygienic infection and shock) and mental trauma.[4,5] Whereas morbidity is high and manifold, mortality is estimated to be very low.[5] Of course it has to be taken into account that most women live in very remote places, and only a small number can reach a hospital in case of an emergency. Therefore the estimate is probably based on an already pre-selected and probably slightly privileged group of women. In general, it is perceived to be a major step to seek help and advice in the hospital, which is often only taken in case of long lasting or severe illnesses.

The head of the women's elders in Jijiga clearly pointed out the frequency with which the women talk about psychological problems related to their circumcisions:

*"Besides the pain that comes with intercourse, with every period and with every urination, as well as with every delivery, the women talk about the trauma and the feeling that they are not whole anymore, as if somehow crippled and being robbed of a fulfilled sexual life, they say they don't have a climax. If you sum this up, it makes more than 80 percent of a woman's life time. They suffer from the age of 6 until they die".[2]*



Women's change of perception concerning the harmfulness of infibulation can be almost exclusively explained by the fact that at some point in their lives they had identified their infibulation as the cause of their various physical complications. Often the time of awareness coincides with extreme illness, which leads the woman and her family to seek professional medical help. Doctors, through diagnosing the cause of their pain, seem to play an essential part in the individual awareness process:

*"I only realized fully what had happened to me around the time when my period came. I am completely sewn up you know, only a small hole is open, even my urine could not pass, how could the blood? I had back pain, fever and I vomited every month. I had to sit or lie down for days and could not move".[1](Somali woman in favor of 'sunnah' circumcision)*

*"I had nine children and four pregnancies ended in miscarriage, and three children died during or just after the delivery; they did not come out in time, only when they cut me open. Because I couldn't give birth, my two husbands divorced me, and I lost everything. Only the last one, who is a sheik, sent me for medical treatment. The doctor told me that my uterus was full of blood and infected many times as the opening that remained after circumcision was too small, so that urine and monthly blood could not leave my body; this was the reason I could not carry out my pregnancies. That was when I realized. Finally I could deliver and raise my two healthy children".[3] (Somali woman, illiterate)*

*"I believe in my case that all the problems come 100 percent from my pharaohnic circumcision. I don't think that all circumcised women suffer as much as the infibulated ones. One time when I had my period I went to the hospital, because I could not stand the pain anymore. The doctor tried to open me and explained that afterwards my pain would go away. When I would not allow it he said that after marriage things would get better anyway - I got married when I was 15 years".[3] (Somali woman who agrees to 'sunnah' circumcision)*

*"I remember when I was circumcised. It had to happen twice, the first time it was not done properly. I am not married yet, so I am still closed and have a lot of inflammation and period pain. Since the time I was circumcised, I have a stinging pain every time I*



*urinate. I am scared of the time when I will be opened by my husband. I wonder how it will be? My friend has her period twice or three times a month. You see, the blood only leaves the body so slowly. The doctor told her to be opened, but this is impossible, even though she is in great pain".[11]* (Young Somali women, unmarried, literate)

An Amharic<sup>43</sup> woman who had, according to her tradition, a clitoridectomy as a small girl noted the following, during one of the focus-groups:

*"I am Amharic, not Somali. This means that I have been circumcised and my clitoris was cut, but I was not sewn close. When I listen to you I realize that I have none of these problems. Even when I gave birth I didn't have these problems. My Amhara friends would say the same, they don't have your problems either".[11]*

The realization that most of the gynecological illnesses are related to infibulation is often a turning point of change in a woman's individual perception. The fact itself, though, is known within the culture, which is shown in the way Somali language knows expressions for illnesses that only occur in infibulated women:

*"Pharaohnic circumcision is not only the cause of pain, it has also an effect on fertility. We call it the 'surati' disease. It is was comes from the blood that cannot leave the body. You have pain everywhere, in your back [points to the kidneys], in your abdomen [points to the uterus] and a strong pain that runs from the back to the legs. When I could not get pregnant I went to the hospital and the doctor confirmed my suspicion, that it came from my circumcision and the fact that the blood stays in the body. After being treated I got pregnant. A friend of mine had a form of miscarriage that is very common. What happens is that you can get pregnant from the clotted blood in your abdomen. But you miscarry an abnormal child from this after a few month. The child is 'umulsabiyen'. We women know about this".[3]* (Somali women's elder in favor of 'sunnah' circumcision)

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<sup>43</sup>Amhara people form a large ethnic group in Ethiopia. Their cultural traditions (food, ceremonies, rituals, clothing, etc.), language (Amharic) and religion (koptic Christians) differ greatly from the Somalian one.





Even though individual awareness is elevated through a personal history of suffering, the final trigger for behavioral change is often religious understanding. As an illiterate Somali woman explains:

*"Since I was circumcised by the age of seven the suffering has never left me. Even when I was a girl, the opening was too small to let my urine pass. It stayed in my body and was very painful, my bladder was never empty. Later when I got my period the blood could not flow. It was always very painful. I got married when I was 14. And I gave birth to three daughters. They were circumcised the same way - the pharaohnic type - as I was. Today, I feel I was ignorant and I did wrong. I can not read nor write and today my daughters read the Koran to me and tell me that it is against Allah's will to do the pharaohnic circumcision. My daughters are not married yet, but I gave permission for them to be opened, so at least they do not suffer". [3] (Somali woman, illiterate, for sunnah circumcision)*

Similarly another Somali woman argued for 'sunnah' circumcision:

*"Since the sheik in the mosque spoke about the fact that the pharaohnic type of circumcision is against Allah's will, I only did 'sunnah' with my three daughters. Now I see the difference, my vagina looks as if it had been burned at the edges and in the middle it is flat like a paved road. Also I lost all my feelings. I think I did good with my daughters to prevent this from them".[3]*



#### 4.6. How changes of perception came about in men

Men see women's physical illness, and they actually feel burdened by their wives' frequent suffering and poor health. They do not necessarily relate infibulation to poor health, as it is perceived 'to be in the women's nature to suffer so much'. But even those men who realize that infibulation is the cause of most of the women's complications do not necessarily change their attitude. What does seem to have an impact is seeing or attending an infibulation. The strongest and most common factor of change seems to be religious understanding. Only 'sunnah' circumcision is seen as favorable according to the Koran and the sayings of the Prophet Mohammed and is supported by religious leaders. There is an indication that whatever cultural changes are made, in order for them to be effective, they have to be acted out in communal compliance.

The process of awareness that infibulation is harmful to women is described by most men as having been triggered by many different factors. All the men interviewed, except one who was still unmarried, were married to infibulated women. The men seemed to realize that their wives suffer physical illness frequently, but they didn't necessarily relate this to infibulation. It was felt by most men (~80 percent) to be an important first step to make the conscious connection between illness and pharaohnic circumcision.[12] A health worker explains:

*"I think that the main factor of change was seeing my wife having so many health problems. I had to pay for hospital stays, doctors visits and listen to her daily complaints. You know, many men think that it is just in the woman's nature to suffer so much of illness and pain and that it is a woman's business. Men don't bring the two together". [9]*

A young Somali man further sums up what all, except one of the interviewees, had stated:



*"I believe circumcision is bad. I do not support it. I discussed it with my friends and we all agree on this. I support the 'sunnah' circumcision. I believe in the religious side of it. I think the initial sowing causes all the complications. That's when problems and bad health comes...".[12]*

The cognitive awareness alone that medical complications and infibulation are related is a first major step, but does not seem to be sufficient to bring active change. Even male health professionals like medical doctors and nurses would infibulate their daughters or answered 'no' when asked whether they would consider marrying an uncircumcised woman.[8] Further, general education (number of school years) and specific knowledge on infibulation and its effects on health alone do not seem to have instant impact:

*"It is a long road to awareness. I remember as a young student in university we had to fill out a questionnaire about circumcision. I answered 'yes' when they asked whether we would marry a non-circumcised woman. I guess I wanted to impress. In my heart though I deeply believed that these women were prostitutes. You know, I had all the education and knowledge, but my heart was unchanged. Only now, 12 years later, when I came to work against circumcision, I started to reflect and read and visit workshops. Today I can openly say that I would marry a woman that is not circumcised".[9] (Male Somali nurse who works for NCTPE)*

One of the main coordinators of the National Committee on Traditional Practices of Ethiopia expressed the same feeling:

*"Don't underestimate the power of an old and deeply rooted tradition like circumcision. It took me four years altogether to fully understand, comprehend and let go of the idea. It was not easy, even though I was well educated, visited many workshops and participated in various courses".[6]*



What does seem to have an impact is seeing or attending an infibulation. Men in general are not present at the operation, but those who have ever had a chance to get a visual impression are deeply impressed and shaken:

*"I cannot bear to see it. Seeing makes a difference. It has added to make my opinion against infibulation stronger. It is very cruel, all this cutting by full awareness...men generally don't have access to circumcision videos. It made me think a lot. I never forgot. It changed my mind. I remember that quite a few of the men who were present to watch the film decided not to do this to their daughters".[12]* (Somali man, educated who will not circumcise his daughter)

*"I have seen a circumcision once myself by accident. I lived in a house with an upper floor and as I looked outside the window I saw that in the neighboring compound a girl was circumcised....I saw it all. It is cruel and I was deeply ashamed. These are unkind people who do circumcision".[12]* (Somali man, unmarried, would not circumcise his daughter)

The strongest and certainly most promising argument for change is religion. All interviewed men, except one, agreed that doing the will of Allah meant replacing the pharaohnic circumcision with the "sunnah" one. "Sunnah" circumcision is seen as equivalent to male circumcision, which seems to be a completely necessary and unchangeable custom at this moment in time.[12] The sheik, who is one of the religious leaders of the community, said this very clearly:

*"Sunnah circumcision is the equivalent of the men's circumcision. The male circumcision nobody can change! That is why our religion calls it "chatam" Which means this is the way it is".[10]*

The sheik also found great importance in pointing out the different types of





circumcision and how they relate to religion:

*"I will start telling you about our very nice tradition of "sunnah" circumcision. This one is the religious one, the good one. All Islamic people believe in "sunnah" circumcision. It is the equivalent of male circumcision. Then there is the other one. It is called "pharaohnic" circumcision. This one is not good. I cannot agree with the latter, I cannot accept it. It does too much harm".[10]*

One of the Somali elders explained how increased religious understanding revealed the difference between 'sunnah' circumcision and 'pharaohnic' circumcision to him and how this awareness had an impact on his behavior over time:

*"My older daughters are circumcised in the pharaohnic way. The younger one's are done sunnah type. There was a change in my mind half way. First I was young and ignorant. But later I became a big man, I was better educated and I knew the Koran. Even my wife, she became more educated over the years. What made me finally change my mind? It was the religion that was most impressive for me. This is what did it to me. But this is a complex matter and people often don't understand...I think the best way to influence people in the community is through religion. You see Somali people are very religious, they are 100 percent religious".[10]*

One of the interview participants exemplified how even guilt and sin come to be attached to the execution of the traditional practice, once religious understanding is present:

*"We are guilty according to the Koran! All of us who pursue the tradition of pharaohnic circumcision. If we want to change what Allah has created so perfect, we are trying to become like Him, if we physically want to change and therefore cut our women".[12]*

Even though Somali people were generally described as being very religious, there



seems to be the perception that uneducated and especially rural people do not know about the distinction between religion and tradition:

*"Islamic religion tells us that we should not circumcise our women in a pharaohnic way. But many people don't know, they cannot read the Koran and the sheiks don't speak out. You know the sheiks can influence the people well. I was very impressed once when I heard the old sheik preaching against pharaohnic circumcision in the mosque during Friday prayers. Such an old man and how he explained everything so wisely. He truly understands everything. His words were very powerful. I was very impressed".[12]*  
(Somali man who supports 'sunnah' circumcision)

Another factor that seems important in terms of making decisions for the future is that any new measure will have to be commonly agreed on and exercised in communal compliance in order to have impact. Only a collective approach was seen as being able to convince those along who still prefer the 'old tradition':

*"Circumcision is a traditional not a personal decision. Personally I would not worry so much whether my wife is open or closed, but according to our tradition, the woman who is circumcised is the better one, the more valued one. We also traditionally believe that the closed ones are nicer, as their vulva is closed, you see. I like this better. I believe in the tradition. I want it to persist. Then again if the community decides commonly to change, because this is the better tradition to follow now, I would go along. I am o.k. again".[12]* (Somali man in support of infibulation)



#### 4.7. Who is responsible for the persistence of infibulation? (...or how responsibilities get shifted)

One of the factors that perpetuates the persistence of infibulation seems to be the lack or limitation of direct inter-gender communication. Married women and men perceive it to be impossible to interfere with their partners' decision about the circumcision of their daughters. Men were thought to reinforce the tradition by being interested in the economic advantage of infibulated daughters and by treating their wives as possessions. Women were blamed for keeping the custom alive by bowing to societal pressure.

During the duration of the focusgroups in which the author went back and forth between questioning groups of men and women, the interesting phenomenon of lack of inter-gender communication became visible. The reason identified for this were that in Somali culture, decisions are traditionally made communally by men, women or youth groups, and the final opinion is presented to the community. The head of one of the major women's groups explains:

*"In Somali culture decisions are made in groups. There are women groups, men groups, youth groups. These groups exist in virtually every community. All issues that arise within the community are frequently discussed within those groups and voiced to the particular elders of the particular group, for example the women elder. She has the power to influence that final decision and then discuss the women's solution further with the men's elder".[2]*

What functions well for certain types of societal decision-making or for building common voices and interests among groups seems to limit the communication between married couples or between individuals of opposite gender. The women saw the persistence of infibulation as clearly caused by the men and vice versa. There was also an overall feeling of helplessness expressed about the impossibility of interfering in either of



the gender's decisions.

A Somali father, married to an infibulated woman, described his frustration:

*"You were asking about who decides in the family about circumcision. I will tell you my story. Three of my daughters are already infibulated, but three are still too small. I told my wife that she shouldn't do it even in the beginning with the first daughters, but she didn't listen. When we got married we didn't talk about this. We did not make an understanding about this matter. I have seen all the dangers that come from infibulation and I can predict the problems for my daughters. That's why today I am so angry with my wife. But what can I do? She will not listen and I can not interfere as circumcision is a woman's business. My wife just lives in tradition so deep".[10]*

The sheik himself equally expressed the problem of men not being able to influence women's opinion on this matter:

*"In my opinion the pharaohnic circumcision should not continue but you see it is the mothers responsibility. See, women don't ask men. Mothers just go ahead and circumcise their daughters. Mothers believe that if a girl is not infibulated she will be a prostitute. It is like this: 'If you have a house with precious goods and a door with a lock and a key, don't you close it and keep it safe?' This is what the women do".[10]*

Even two highly educated Somali fathers, who are medically trained health professional and whose wives are infibulated, made a similar statement:

*"I have three daughters and they are still too small to be circumcised. When the time comes they will be circumcised. I can't avoid this. Their mother will take them and do it. She will not listen to me. This is a woman's business and I don't interfere".[5]*

*"The women are the ones who want this tradition most to persist. They do it to their daughters when the father is not present, the day he leaves the house".[12]*





The male health professionals at the regional health bureau voiced similar opinions and pointed out the mother's responsibility in that respect:

*"Men are dominant and make all decisions, but there are areas where men can't do anything. It is a mother's duty to preserve the girl's family by circumcising the daughters".[8]*

Another Somali elder explains further how the women obey societal pressure by infibulating their daughters:

*"It is the women who want the tradition most to continue. Women have stronger feelings about why they do it than men. Every mother wants her daughter to be married off well, she is afraid of society, she is forced to do this. The men don't strongly want this tradition to continue".[12]*

Grandmothers were thought to be an especially crucial factor in the persistence of the tradition, as neither the husband has an influence on his mother, nor the daughter-in-law on her mother-in-law.

The realization that the women themselves are viewed as the strongest opponents of change by the majority of men in the community was passionately rejected by the women. In the subsequent focus group that was composed of members of the local women's group, the women explained why men, despite what they say, are definitely responsible for the existence of infibulation. Women saw the involvement of men in the circumcision discussion mainly due to two main factors: the financial interest on the



father's side, in fact some of the women named the father "the man who sells his daughter"; and the husband's idea of owning his woman. A Somali member of the woman's group explains:

*"The problem lies with the men! Clearly they are the cause that this tradition persists. When they marry they want to see whether their wife is sewn up, they get satisfaction by thinking that she is a virgin. If she is 'sunnah' circumcised, he cannot test, so he will believe she had many man".[11]*

Other voices, like the following from an infibulated young mother, were common:

*"If I think of the cause, I say it is twice the men! It is the father who accepts the dowry and it is the husband who wants a circumcised wife! You see, if the woman is not sewn up properly then he will give the wife back to the family. And the father knows that the tighter his daughter is sewn, the more dowry he can ask. So, in fact it is both the husband's and the father's fault".[11]*

#### **4.8. Solutions and ideas towards ending infibulation**

It was interesting to see that the suggested solutions for change varied according to whether or not people had had formal education and were familiar with the proposals of international and UN agencies, like the health professionals.

The educated group generally repeated ideas and guidelines given by the international organizations, by the Inter-African Committee (on traditional practices



affecting the health of women and children<sup>44</sup>) and by the National Committee on Traditional Practices Ethiopia (NCTPE) which undertook education, information and awareness raising efforts.

Women and men from the community, with mostly little formal education however, discussed and expressed culturally based, sensible, pragmatic ideas of action and change.

#### 4.8.1. Solutions suggested by health professionals and members of the National Committee (NCTPE)

Solutions that health professionals and NCTPE members<sup>45</sup> suggested towards ending infibulation can be seen as being in accordance with the UN agency's and other international organization's approach to information dissemination and awareness raising. This is felt to best be achieved through media interventions; influencing the leaders in the communities; TBA-training<sup>46</sup>; and the creation of job opportunities for circumcisers. Surprisingly all members of this group, except one, opted for a step-by-step approach contrary to the UN's directives and favored 'sunnah' circumcision as a promising intermediate goal. Further, all mentioned the importance of grounding any actions on humane and culturally sensitive criteria.

Following the question: "In your opinion, what do appropriate interventions look like?" the answers can be categorized in 1) 'sunnah' versus infibulation; 2) media intervention; 3) influencing religious leaders, community leaders, elders, women's organizations, health workers; 4) TBA training; 5) creation of alternative job-opportunities

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<sup>44</sup>The Inter-African Committee's (IAC) goals are: short term to create awareness of adverse medical, psychological, social and economic implications of FGM; long term to eradicate FGM by the year 2000, to restore the dignity and respect of womanhood and thus to raise the status of women in society.[9]

<sup>45</sup>See chapter 2.11. for similarity of ideas.



for circumcisers; and, 6) general considerations. [1,4,5,6,7,8]

1) All interviewed health professionals and NCTPE members, except one [7], surprisingly opted for a step-by-step approach in order to end circumcision, which is contrary to the UN agencies attitude. In practical terms this means favoring 'sunnah' circumcision as the most feasible short term solution<sup>47</sup>[1,4,5,6,8].

2) Media interventions were seen as appropriate in many ways:

- Radio documentations: Somali tradition is an oral tradition which is based in a nomadic culture. Listening to the radio is a popular collective activity. For example, people in the community would meet in the evenings to listen to the news and other political or public broadcastings. Members of the NCTPE suggested broadcasting documentations like recordings of personal interviews with circumcised women and their husbands.
- Circumcision videos: Similar to the experience of the interviewed men in Jijiga, health professionals saw these films as particularly impressive and potentially attitude changing.
- Posters, T-shirts and other visual material

3) It was commonly agreed that the most important people in the community who have to

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<sup>47</sup>Two of the medical doctors even spoke out for the promotion and performance of 'sunnah' circumcision in the hospital for no charge.





be educated, informed and made aware are:

- Religious leaders: Sheiks are perceived as the most influential people in the community. They can encourage Friday discussions in the mosque, where all types of problems and solutions are openly talked about on a weekly base. They also can speak about the message of the Koran, which is clearly against infibulation and for the promotion of respect towards the nature of men and women as Allah has created them.
- In order to "prepare the grounds for the good seeds to grow"[1] awareness needs to be further created among the following locally most influential people: local administrators, tribal leaders, elders, educators and teachers, local youth organizations, women's organizations and health professionals.
- Once these groups are convinced about the harmfulness of infibulation, open meetings in common places (mosque, church, village center, market, schools, etc.) should be held in order to conduct open forum discussions.
- To legally outlaw infibulation at this point in time was a controversially discussed step. As much as most of the health professionals would like to establish a constitutional base, there was a lot of apprehension, due to fear that legal punishment would drive the practice underground. Essentially there was agreement, that public awareness needs to be much more elevated before legal sanctions would be appropriate. It was suggested that it would be better to build on the new National Policy that declares women as fully equal to men in all societal sections (landownership, marital rights, etc.).



4) TBA (traditional birth attendants) training was seen as especially significant as they carry a significant role as health educators. They enter into every home and could do house-to-house education. Therefore, it was noted as a promising attempt to further educate and professionally train TBA's, who were previously circumcisers, as birth attendants and health workers. To keep them from continuing to practice circumcision, it will be important to have them taking an oath on the Koran not to perform circumcision any more or to harm their patients in any way.

5) The above mentioned training of TBAs represents one possibility for an urgently needed alternative source of income generation for circumcisers. If they are to be successfully kept from pursuing their former activities, job opportunities should be opened for them so that they do not work in the 'circumcision' market anymore.

6) General considerations:

- It seems a noteworthy fact that for the Regional Health Bureau at the Ministry of Health, circumcision is not a priority issue. Members clearly explained that, just like HIV/AIDS, circumcision can not be a project in itself. It is too time and cost consuming, which is reflected in the fact that even the newly designed adolescent health project for Somali National State did not include female genital mutilation as a focus. It is felt that there are multiple other infectious and communicable diseases (TB, malaria, etc.) as well as neglected immunization and diarrhea-



reduction efforts (EPI coverage of 6%; ORT use less than 5%) that need time and attention more urgently.[8]

- For health educators who are 'newcomers' into the community, it is advised to make personal contacts in the community by making use of the local custom of food, tea and chat invitation. As one of the NCTPE members explained: *"If a person gives you something to swallow, you will never turn against him or her in the future".[1]*
- Another important suggestion was that on principle local experts should be employed on the regional level. It was felt that ideally educators are a selected, small number of community accepted people 'from within' with good training and education and familiarity with the local customs, conceptions and language.
- Illiterate<sup>48</sup>, rural and nomadic people need special attention and probably a very different strategic approach as their general education is very low and their access to mass media or health care is minimum. One very popular educational effort is the "Theater for Social Change", a travelling street theater composed of children and youngsters. Its success seems to relate to its entertainment value.[6]
- It is important in the future to integrate and coordinate all activities that aim

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<sup>48</sup>To bring a strong message across to illiterate people in an appropriate and sensitive way seems very difficult. As the Secretary General of the NCTPE explained, experience shows that even posters are often more a communication barrier than an effective medium. If tribal specific messages (typical faces, typical cloth, ritualistic instruments, etc.) on posters are not correct, they will not be recognized by the community. Somali women commented that the people on the posters looked like 'Arabs' and the little girl resembled a boy; therefore they did not associate the poster with their custom.



towards ending circumcision. Therefore a collaboration between the Ministry of Health, the National Committee and other international NGO's should be established.

7) Finally a few crucial humane and culturally sensitive criteria for a successful campaign were repeatedly expressed during the interviews:

\*Convince people. This is felt to be essentially different then forcing them towards a new opinion.

\*Acknowledge that different places are home to different people with different ideas.

\*Make a peaceful change, a change that does not hurt people and especially women again.<sup>49</sup>

\*See your activities as an exchange of experience, not as a teaching event.

\*Find the solution to the problem within the community. A NCTPE member explains how important it is to make use of people's own perception:

*"Let me tell you a story. A teacher in a town nearby tried to start a literacy campaign for the adult people in the community. He tried to get everybody to school on Saturdays, but nobody showed up. Even after month and month of trying he was not successful. So he was fed up and wrote in big letter on the wall along the school: "Illiterate people have the evil eye-power!" Guess what, word spread and next Saturday everybody came to school. That's what I mean with solving the problem from inside. May be there is a*

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<sup>49</sup>This attitude of a sensitive and careful approach was formulated in many ways: *"We have to go slowly - as in the villages, life is as it was when Allah left after creation."*[8]





*similar solution to circumcision?"[6]*

A further example for how the circumcision issue could be responsibly handled by the people themselves was given by another NCTPE member, who chairs the executive committee:

*"School education could make a major change, if only more children would go to school. We heard the story of the girl who knew that her little sister would be circumcised on this morning. She went to school, collected her friends and the teacher who had told them about the harmfulness of the practice and brought all these people back to her house. The matter was discussed and fought out and finally the girl won and the circumcision was never performed. This is what I mean with 'handing the matter to the people'".[7]*

#### 4.8.2. Solutions suggested by men and women from the community

Men and women from the community both favored the ending of infibulation. Their suggestion towards reaching this goal was two-fold: 1) establishment of a 'sunnah' ceremony center, located at the women's group meeting place, in order to provide access to a professional midwife/nurse who performs 'sunnah' circumcision; and, 2) convincing men to marry uncircumcised women by rediscussing several effective arguments based on people's cultural beliefs.

All solutions that were discussed within the community focus groups have to be seen against the background of an overall agreement that "pharaohnic" circumcision should in the future be replaced by 'sunnah' circumcision. This was equally felt by the attending men as well as the attending women in all interviews [2,3,10,11,12]. All 40 women, for example, that were present at one of the meetings of the zonal women representatives of Somali National State in Jijiga said that even though they were



infibulated themselves, they all agreed that female circumcision is a harmful traditional practice. My further question, whether this meant that in their opinion circumcision should be eradicated, created a heated discussion. The conclusion was that all desired the ending of the 'pharaohnic type' of circumcision and the persistence of the 'sunnah' type. Overall only one women spoke for total abandonment of any type of circumcision [3] and one man against ending the pharaohnic type [12].

Therefore the one major common solution towards ending infibulation was seen in taking practical steps towards making 'sunnah' circumcision easily available for women. Practicing solely the 'sunnah' type of circumcision, or in other words celebrating the 'sunnah' ceremony, would in fact mark the end of circumcision for the local people. The process was presented as a two-fold one which actions should be pursued simultaneously. First, practically providing access to a female health worker, ideally a midwife, who is in charge of a simple one bedroom health facility where 'sunnah' circumcision can be performed, was seen as the major component and, secondly, there was a perceived need to openly rediscuss inherent cultural patterns of traditional thinking. [3,10,11,12]

1) The women made it very clear, that they would want this health facility to be closely connected to the women's group meeting place and in no way connected to or supervised by the hospital. To locate the center outside the hospital seems to be a crucial factor. It would first of all allow women to be in charge and work effectively through the traditionally established network of the woman's group. Second, it would take away the barriers that hospital visits represent for women. As the sheik explains: *"All men go to the*



*hospital for circumcision. But the women don't go, they are ashamed".[10]* Further it was clearly recognized by the women that the preference of 'sunnah' circumcision over infibulation reflects an educated, urban and advanced attitude. The women were convinced that at this point in time not all women in the region would share their knowledge and attitude. Therefore they saw the advantage of having an easily accessible, nearby "sunnah ceremony center" connected to the women's meeting place as an opportunity to reach out to all women and make it easy for them to casually acquire knowledge and information in a non-threatening way. As one of the women elders remarked: *"To influence women always works best through the women's groups".[11]*

There was also a feeling of increased urgency that made it reasonable to delegate 'sunnah' circumcision to professional health care workers. In the past, girls used to be circumcised without any anesthetics, but today, being pressured by the parents, the circumcisers seem increasingly able to obtain drugs and syringes, yet without having the knowledge on how to sterilize or use the equipment properly.[11]

Two of the women elders sums up the women's discussion of future solutions:

*"If we talk about 'sunnah' versus infibulation, we will find the Somali people in Somali National State in two opposing groups. Those who prefer the 'sunnah' type are especially the educated and urban ones...In the rural areas the tradition is very strong and there is no knowledge and no health care whatsoever. These are the ones I worry most about. But you know, despite all this, I think it would be very easy to come back to 'sunnah' circumcision. Once people start to notice how things are related [medical problems due to infibulation]..".[11]*



*"To have a 'clinic' at the women's group would be the solution. This is safe and good because the culture is preserved and the ritual is fulfilled. But the women will not be destroyed anymore, they are able to enjoy their married life now and be fulfilled...imagine if everybody is "sunnah"? There is nothing more to fear, we are all protected then. If you count one small clinic for every zone, we will need 9 altogether for the entire region. I tell you it would be over in three years. The change would come about so fast. The people are prepared".[11]*

2) The second most important step is to convince men to marry and accept uncircumcised women. Several effective arguments, based on the cultural belief of the people, have been put forward to encourage men to change their attitude towards uncircumcised women. It was strongly felt that the following points should be rediscussed in the community:

\* Men and women both felt that the community needs to be made aware of the fact that the virginity of a woman is not determined by how tightly she is sewn up. And again, women perceive men as the ones who do not have any knowledge about this issue and vice versa. A Somali father, married to an infibulated woman said:

*"I think that the study of virginity is very important within the community. People don't see that virginity is internal. The mothers think that as long as their daughters are sewn up they are virgins; they don't know that virginity is a internal thing. Women can always be sewn up again, even after a delivery. Until people understand this, there is no solution. In Amharic culture they use a little white cloth in the wedding night to see the bleeding. This is their proof and they understand that virginity is internal".[12]*

A women's elder from the local women's group similarly explained:





*"A woman's virginity is internal. Men don't know that. Lets say she has contact with a man but he doesn't penetrate completely, only a little bit, if she is sewn, then she can still get pregnant<sup>50</sup> and the baby takes her virginity at birth. I think we can use this argument together with the religious one [female circumcision is not stated in the Koran]. There is a proof of virginity, even if a girl is only 'sunnah' circumcised as her virginity is internal, inside the vagina".[11]*

\* The interest of men in infibulation is mainly reinforced and maintained by the dowry system. If women have, for example, other 'qualities' like better education and the ability to contribute to the income of the family such as vocational skills, they are seen as equal or even more desirable than those who are infibulated. As a leading Somali woman explained:

*"If we educate women to earn their own small income and in this way enable them to contribute ongoingly to the husbands family's income, she might be of great value to him, even if she is not infibulated".[11]*

Another major factor in preferring a non-infibulated wife is seen in the fact that these women are far healthier and more content (see chapter 4.6.).

\* Further, *"men need to understand that serious marriage problems that come later because women are never interested in sex"[12]* will be avoided if women are not circumcised. A married Somali man illuminates this point:

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<sup>50</sup>The way the women aim to explain this argument to the public is to clarify the well known fact that after the three days of engagement, when the couple is not married yet and therefore the bride is still 'closed', at times pregnancy follows: *"She is not cut open at that time, but she often gets pregnant - this proves to the people that virginity can be destroyed even with pharaohnic circumcision".[11]*



*"Women are injured at that place of their body so many times, of course their sexual interest is reduced. I have experienced that with my wife and I talked to my friends. Most women have no interest in sex. Their sensations are removed with circumcision, how could they?"[12]*

\* Another reasoning against infibulation is the violation of a woman's right and duty to pray and to be heard by God. Again, men perceive women as ignorant to this fact and vice versa:

*"Many women don't know that they are unclean. Before prayer everybody is supposed to urinate and wash the genitals and all other parts of the body. Because the women are sewn up, how can they wash inside? They are closed. Look at my fingers, if they would be sewn together, how would I be able to wash between them? As I said, the women don't know this, but we men and the religious leaders know".[12]* (Somali elder, men's group)

*"Oh, we sewn-up women are not even heard by Allah! You see, we pray five times a day. Every time before the prayer starts we wash our hands, feet and the face. Equally we should empty our body as best we can, at least the bladder. If you do not perform your cleaning rituals properly, you are considered unclean and your prayer will not be heard by Allah. But how can we pharaohnically circumcised women clean our body? Our urine does not flow, or it is very painful and takes a long time".[11]* (Somali woman, infibulated)

#### Other suggestions:

Similarly to the health professionals opinion, the help of the law was mentioned as a measure that will be applicable only in the future, if societal attitudes have changed. Instead of outlawing circumcision at present, it was preferred to effectively make use of



the newly constituted Ethiopian Policy on Women (see chapter 2.12), which favors the equality of women on all societal levels. The women agreed though that if infibulation was legally punished in the future it would partly take the pressure of the parents and the grandmother in terms of making the decision for or against it:

*"The law has to help us in the future as well. You know, we ourselves as the women's group have asked the elders in the community some time ago how to stop the tradition. For example, if you kill a man today in our town, you will hardly be punished. And we came to agree with them, that in the same way circumcision should be punished, once people understand what they are doing".[11]*

#### 4.8.3. Suggested long-term benefits as expected by local men and women

Participants from the community were convinced that the change from infibulation to 'sunnah' circumcision is possible in a fairly short period of time, and that this change would influence the society in a positive way. Long-term benefits to the individuals and to society were seen as multiple.

When asked by the author whether the change from infibulation to 'sunnah' circumcision was possible, all participants agreed that it can be changed 100% and stated that this change would influence the society in a positive way. In fact multiple long term benefits to the individuals and to society due to the ending of infibulation were suggested. The following quotations give an example of what women [11] stated...:

*\*"All our long term problems would go away, we [women] can be much more productive".*

*\*"The whole dowry business would go away. You can not estimate the prize of the bride according to her vaginal opening anymore".*

*\*"Divorce based on arguments that women are not sown up properly would decrease. It*



*is no longer possible for the husband to complain. The other thing is the men who have women that constantly have pain start to see other women. So you see how infibulation affects the happiness of both".*

*\*"Being healthy is our biggest happiness and oh, we would be so happy then!"*

*\*"We would enjoy our married life much more as our sex-life would be without pain"*

*\*"Nobody will be accused anymore of being too wide open or not being sewn-up enough or for being 'sunnah' only. Every woman is open then and every woman is as she is".*

.....and of what men [10,12] voiced:

*\*"Physical pain and medical complications would be greatly removed from the woman".*

*\*"The 'love percentage' amongst the couples would be higher as both would enjoy equally".*

*\*"There will be an agreement about the issue of circumcision at the time of marriage. Both would agree not to circumcise their future daughters. It should be like a contract and talked about up front".*





## 5. Discussion - A Project Proposal for Change

### 5.1. Hypothesis

In order to start the dialogue at its most critical point, a hypothesis was developed, based on my research findings in Ethiopia's Somali National State and is subsequently presented for discussion:

#### Hypothesis:

"The creation of a 'sunnah ceremony center' (one-room unit attached to the women's group meeting place, staffed by a professionally trained midwife that practices 'sunnah' circumcision<sup>51</sup>) would greatly reduce the prevalence of infibulation and as a consequence prevent infibulation related short and long-term illnesses. It would further reduce the risk of infection due to unhygienic practice and provide women in the communities with the opportunity to choose a safe, enclosed and protected place in which they can fulfill the cultural rituals of this deeply embedded traditional practice. The center would act as a clearing house for information, education, referrals and treatment of circumcision related concerns and complications and of reproductive health related issues (gynecology, mental health, non-maternity health). It would also empower women to acquire knowledge about wider issues of health, well-being, development, education, etc. that they perceive as important to them"

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<sup>51</sup>Professionally done 'sunnah' circumcision, by a practitioner who has great knowledge of the female anatomy, is the piercing of the skin on top of the clitoris in order to cause some ritual bleeding. It does not involve any cutting of skin.



## 5.2. Illustration of major arguments

The above outlined project proposal clearly challenges international organizations including UN agencies to formulate a new circumcision policy. This challenge is not a small one. Female genital mutilation is viewed as "one of the most serious issues of our time" by leading ethicists, and "these issues are currently at the forefront not only of feminist agendas but of all international health assistance agendas" (Farley 1996).

A first step towards a thorough policy change is the re-discussion of the ethical soundness of presently ongoing "eradication and elimination campaigns" against FGM, as outlined in major UN Directives (WHO Feature 1995; UNICEF Executive Directive 1994; Joint WHO/UNFPA/UNICEF Statement 1995) and executed by National and Inter-African Committees.

Secondly the question of the universal applicability of international human rights versus cultural sensitivity has to be confronted. In this particular case it is the question of whether a so-called step-by-step approach, as presented in the hypothesis, is justifiable. Is a harm reduction approach warranted, in opposition to an elimination strategy? If so under what assumptions and based on what arguments<sup>52</sup>?

### 5.2.1 Ethical concerns towards current "Elimination and Eradication" strategies

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<sup>52</sup>The underlined passage in the following text is the major statement in each case.



#### 5.2.1.1. Effectiveness:

Analyzing the feasibility and impact of any measure, in order to be effective, is ethically extremely relevant and required (Farley 1996). United Nations (UN) organizations, Non-governmental organizations (NGO), and various international committees like the National Committee on Traditional Practices of Ethiopia (NCTPE) and the Inter-African Committee (IAC) work in specific countries and worldwide toward what they call "elimination", "eradication" or "abolishment" of FGM<sup>53</sup>. Their success seems small in comparison to the resources they use. Thus, it is legitimate to question the sufficiency and appropriateness of their approach. Most FGM eradication efforts have launched campaigns designed to educate and sensitize the people concerned, to raise their awareness and to disseminate information to health professionals. This strategy can be considered as a first step. It lacks practical translation into action on the grass-roots level and has therefore only had a small overall impact. In Sudan, for example, there have been education campaigns since the 1940s yet, infibulation is still over 90 percent prevalent (Dorkenoo in: Armstrong 1991, 47). Even if people are educated they might not necessarily give up the traditional practice. Studies in Ethiopia in 1985 (Harmful Traditional Practices 1985) and 1994 (Raedda Barnen 1994) showed that over 70 percent of literate and informed respondents indicated that they would have future daughters mutilated. Therefore it can be concluded that there is an urgent need for practical

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<sup>53</sup>WHO: "Ongoing battle against circumcision" (WHO Feature 1995); UNICEF: "Guidelines for Action on Eliminating and Eradicating" (UNICEF Executive Directive 1994).



programs on the community level.

#### 5.2.1.2. Paternalism and ethnocentrism:

It is a clearly ethnocentric approach to identify wrongs or rights within a foreign culture. The tradition of circumcision has long been a source of conflict between Western and African values (Merwine 1993).

Defending a cultural identity becomes especially important when groups have faced outside pressure or oppression e.g. under colonialism (Toubia, IJGM 1994). In 1929, for example, the effort of a Christian reverend of the Church of Scotland led to the beginnings of cultural nationalism among the Kikuyu tribe. He demanded that native Christians abandon the practice as it is medically unhealthy and religiously the work of the 'evil' and therefore "entirely unnecessary" While some Kikuyu accepted these arguments, many rebelled (especially among the women of the tribe) and started a movement of awareness to make people conscious that their age-old traditions and cultural survival was at stake. Today the controversy is often credited with the beginning of emancipation of Kenya from the European influence. Resistance to the elimination of circumcision has continued to be one of the cornerstones of African leader's politics. Jomo Kenyatta, the leader of the anti-colonial movement and the first president of Kenya used to say, "Excision and infibulation unite us tightly; they prove our fecundity" (Aldeeb 1994; Dorkenoo 1994).

Equally, Muslim circles in favor of female circumcision see an imperialistic action





in the Western campaign against it. They argue that if the West is trying to forbid circumcision, it shows that they have succeeded in imposing secular materialistic views on Islamic science, tradition and artistic culture (Aldeeb 1994).

Repeatedly, in the recent history of UN conferences, African women stopped the proceedings of meetings in order to show their protest against the interference from outsiders, mainly Westerners. Representatives did not want to discuss the matter in an international forum. Cross-cultural communication problems hindered constructive problem solving. Western feminists saw the "over-sensitive" attitude of African women as a reason for the slow rate of change. African women saw the problem as a deep rooted, traditionally sanctioned practice which should only be tackled within an "African context" (Harmful Traditional Practices 1985). The majority of African women who work to end female circumcision take great exception to the western focus on FGM as portrayed by western authors. Alice Walker's novel, for example, 'Possessing the Secret of Joy' and her film 'Warrior Marks' are seen as:

"...emblematic of the Western feminist tendency to see female genital mutilation as the gender oppressions to end all oppressions. Instead of being worthy of attention itself, it has become a powerfully emotive lens through which to view personal pain - a gauge by which to measure distance between the West and the rest of humanity" (Dawit 1993).

The paternalism also is practiced by economic means. In fact, it is often proposed that international aid in the form of loans and grants be cut if governments do not comply with the donor's attitudes and ideas on how the money should be spent.



"To demand...that economic aid be used to force a change in a tradition [circumcision] so central to many Africans and Arabs is the height of ethnocentrism" (Merwine 1993).

State Department's human rights reports now require African countries to report on the incidence of genital mutilation and "...influential lawmakers and commentators have called for discontinuing financial assistance to governments that do not address this issue in the manner dictated by the West" (Dawit 1993).

It is ethically important to see this crucial link of foreign aid and political dependance. Even the implementation of international human rights is often enforced from "top-to-bottom" The unwillingness of Western agencies to listen to local voices and their suggestions means that culturally appropriate and sensitive proposals for social change often go unheard. The only ethically acceptable interventions are those which originate from within the culture. The African professional women living in the US, working to end FGM declare:

"We do not believe that force changes traditional habits and practices. Superior Western attitudes do not enhance dialogue or equal exchange of ideas...A media campaign in the West will not stop genital mutilation. Westerners and those of us living in the West who wish to work on this issue must forge partnerships with the hundreds of African women on the continent who are working to eradicate the practice. Neither Alice Walker nor any of us can speak for them; but if we have the power and the resources, we can create the room for them to speak, and to speak with us as well" (Dawit 1993).

#### 5.2.1.3. Cultural Context:

It is fair to assume that human behaviors and cultural values, however 'senseless or destructive' they may appear to other people's personal and cultural standpoints, have



meaning and fulfill a function for those who practice them. A very interesting observation is that "in communities where infibulation is the norm, it has been noted that many families revert to clitoridectomy when health education programs commence" (Joint Statement 1995, 7). What this shows is that even if people do understand the harmfulness of the tradition, they keep believing in its cultural value. This is also reflected in the fact that even health professionals would circumcise their daughters (see chapter 4).

Successful efforts to stop FGM must therefore go beyond the medical model of disease eradication. They require a full understanding of the socio-cultural, economic and gender context in which it is practiced (Joint Statement 1995)<sup>54</sup> The aim should be to convince people, both men and women, that it is possible to give up harmful practices without necessarily giving up meaningful aspects of their culture. Viewing other historical examples of mutilating traditions and their eventual eradication (e.g. foot-binding in China<sup>55</sup>) it has been shown that successful interventions "...considered carefully not only eliminating but replacing the custom" (Dorkenoo 1994, 16). It is important to identify non-harmful alternatives to FGM that could continue the important and positive aspects of the cultural initiation for girls into adulthood and training for social responsibility

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<sup>54</sup>Toubia N., the most famous women's advocate against FGM in the US points out how cultural identity is of paramount importance to everyone: "If we compare for example western health risks, we see that women in the US who have big economic power still undergo cosmetic surgery, strict diets and wear uncomfortable clothes and shoes, in order to comply with their societal expectations" (Toubia, lecture 1994).

<sup>55</sup>Foot-binding was only definitively stopped by a massive social and political revolution. This revolution replaced the many traditions which it swept away by offering an entirely new social system, revolutionary in many aspects: landownership, education, sex equality, etc.



(UNICEF Directive 1994). "Where mutilation is traditionally tied into a initiation rite, we should try to substitute the ceremony with much more positive ways of celebrating maturity" (Stelzenmueller 1995,16).

#### 5.2.1.4. Social Context:

Effective discussion around circumcision has to consider the background of the total economic and social make-up of the particular societies in which it takes place:

"Genital mutilation does not exist in a vacuum but as part of the social fabric, stemming from the power imbalance in relations between sexes, from the levels of education and the low economic and social status of women" (Dawit 1993).

In traditional societies women have seen their sexuality, over centuries, in terms of what suits the community and its leaders, which often were men (Dorkenoo 1994). The social structure of the Ethiopian society, for example, in the past and in the present was such among settled and nomadic groups, that land inheritance was exclusively through the male line; hence, a premium came to be attached to the virginity of the bride and the faithfulness of the wife. Virginity became a money making asset and was insured through methods like infibulation. Today it is a fact that the dowry is higher if the girl is a virgin at the time of her wedding which is demonstrated by a minuscule vaginal opening and achieved by a severe infibulation (see chapter 4).

Further, the extended family is the principal source of social and economic security and has not yet been replaced by the 'modern' state and the concept of individualism and





independence. Women still have very few options of securing their future outside of marriage. Cultural identity is often still stronger than individual interest (Toubia, NEJM 1994)<sup>56</sup> Ethiopian and Somali culture is deeply based on community and collective values as well as cooperation at the village level. Equally high moral values apply to family cohesion. Those who fail to accept the principles of fulfilling the group's obligations and do not act according to its rules and regulations, forfeit the privileges and benefits available to the rest of the community, and thus are ostracized. Female circumcision, up to this day can be viewed as one of these important rules, which if disobeyed, ostracizes individuals and families from their social group. The male heads of the families in which daughters and wives are not circumcised, presently lose the benefits that the community can offer; women lose their matrimonial status, and entire families are outcast (Jugessur 1993)<sup>57</sup>

My own research findings suggest that keeping the social inherent concepts of the culture in mind instead of solely focusing to end infibulation is the more promising strategy. Giving direct attention to specific traditional practices like e.g. forced marriages of young women, dowry for the benefit of parents and customary demands of proof of

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<sup>56</sup>Societal values have long been neglected in Western research: "...cultural biases sometimes have been mistaken for universal truths because almost all of the research subjects and researchers in the last 50 years have been Americans and Europeans. Western cultural beliefs tend to dominate psychologists assumptions, especially about individual rights and community responsibilities" (Miller 1995).

<sup>57</sup>A Somali mother from the community told me that when it became obvious to her family that she was not willing to have her daughter circumcised, the girl was literally kidnapped by the grandmother and an aunt and given back only after infibulation was performed. The family felt it was the only way to avoid shame and disgrace.



virginity before marriage, that seem to directly or indirectly sustain the perpetuation of female genital mutilation might impact the parents' decision on whether or not to circumcise their daughters far stronger. The women in the community felt that especially the discussion of concepts like virginity, pregnancy, fertility, etc. among the members of the men and youth groups will encourage men to marry uncircumcised women in the future (see chapter 4.8.2.).

Considering the circumcision discussion as inter-linked into a specific social context seems crucial. Eradication of one practice might easily eradicate other favorable cultural traditions. Promoting the well-being of all, not merely attempting not to harm them, expresses one of public health's goals and justifications. It is extremely difficult to foresee long-term effects and to predict outcomes, especially the consequences of a societal change. Nevertheless public health practitioners have an ethical obligation to weigh and balance the possible goods against the possible harms of an action. Trying to end a widely prevalent (99 percent) traditional practice like infibulation will most certainly evoke changes in other fundamental societal patterns such as attitudes toward marriage, relationships between men and women, attitudes towards children and community life, attitudes towards familial values, religious beliefs, and many more. Eradication campaigns could cause much harm:

- They could weaken a culture's identity and pride by bringing its deepest and most intimate patterns of sexuality into the spotlight of the global family. One of Germany's major tv channels broadcasted a documentary about circumcision in



Somali National State in 1993 that spontaneously encouraged the German public to donate DM 2 million for a promised "eradication campaign". The channel also received thousands of letters from people expressing their disgust and agitation. In December 1995 another team of journalists planned to do a follow-up documentary in order to see what change the monetary assistance had had on the circumcision practice.<sup>58</sup>

- These campaigns could also harm the emotional and mental integrity of those women who are already infibulated, by stigmatizing (especially as there is no possibility of remediation) and traumatizing them. The latter is an argument that psychologists have put forward. In the process of becoming aware, a psychological trauma is re-experienced -- or consciously experienced for the first time -- and might only now start to have destructive impact on the person's mental health, especially if it is in direct opposition to accepted cultural norms:

"The notion of sexual victimization is not felt while women and girls remain firmly within their own culture...It is difficult to assess the psychological damage of a tradition which is so universally accepted. Once education and emancipation bring realization of victimization, however, serious psychiatric breakdowns could occur.." (Cloudsley 1983, 127).

This notion has to be taken the more seriously, as access to mental health care is non-existent for the majority of women.

- These campaigns could deny marriage prospects to a whole 'transitional generation of young girls.

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<sup>58</sup>Results of this follow-up are not yet available.



- They could create major splits in the cohesion of the community and family life (some families and family members will adapt more rapidly than others).
- The eradication approach could increase the disparity between urban and rural communities as urban settlers are far more likely to change more quickly.
- They could also increase the inequality between rich and poor people. Studies show that socio-economic status has little impact on a family's decision of whether to circumcise a daughter or not. But women of higher socio-economic status are far more likely to be circumcised by a trained midwife or even a doctor in the hospital (Raedda Barnen 1994).





### 5.2.2. Arguments in favor of a step-by-step approach

#### 5.2.2.1. Empowerment and advocacy:

The idea of a 'sunnah ceremony center' was developed by the women themselves. It is what they want and what the religious leaders and elders of the researched community support and what they finally aim at (see chapter 4), as they perceive the 'sunnah' type of circumcision as the one recommended by Prophet Mohammed and the Koran. Suprisingly, even the health professionals opted for the 'sunnah' circumcision as a beneficial intermediate goal.

Even though UNICEF (Progress 1994) states that the lead should be taken by women from societies in which the practice is prevalent, African women's voices are often not taken seriously. True acceptance of a nation's own pace of development and of the women and men in the countries concerned will be expressed once UN agencies as well as international organizations and donors are prepared to assist and support the local people's own proposals for action. This support of local people's ideas would more clearly express the believe that other countries can equally set their own agendas, given the opportunity for informed choice and time. As my research findings in Ethiopia suggest there is clearly a movement of 'enlightenment'<sup>59</sup> that should not be discouraged but rather mandated and assisted. International organizations and UN agencies would do better to act as political advocats for the local women and men by supporting their ideas, thus enhancing their ability to make their own decisions and be heard in the international policy arena. This

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<sup>59</sup>The women themselves developed the idea of the 'sunnah ceremony center', which indicates a major shift in normative perception.



support would further secure a genuine participation of the indigenous societies and an ongoing dialog among all parties (Slye 1996).

#### 5.2.2.2. Cultural sensitivity versus universality of human rights:

In 1990 the United Nations Convention on the Rights of the Child went into force and became part of International Human Right Law. Art.24(3) states explicitly that: "State parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children" The goal of implementing programs on community level was clearly set:

"Members of the UN should work at translating its provisions into specific implementation programs at grassroots level...Those UN agencies and government departments specifically entrusted with the health needs of women and children must realize that it is their responsibility to support positive and specific preventative programs against female genital mutilation, for while the practice continues the quality of life and health will inevitably suffer" (Dorkenoo 1994, 16/17).

Proponents of eradication campaigns believe that any other form of action (other than the "elimination" of the practice through education and awareness creation) violates internationally agreed upon human rights. Yet, the long-term goal to end any form of female circumcision is also (and probably even stronger) fulfilled by a step-by-step approach such as the performance of 'sunnah' circumcision. This goal is the first premise of any intervention and is non-negotiable.

Finding practical solutions and working in incremental steps can therefore be perceived as strategies which more actively respect and apply international human rights



declarations like the 'Convention on the Rights of the Child'<sup>60</sup>; more so, then eradication campaigns by themselves. The women's decade has helped to make the world realize the importance of gender equality. Today women's rights are accepted as human rights to be protected and defended. This is not a discussable question but much rather how these rights can be implemented sensitively and effectively at the grassroots level.

Ideally, programs should be well funded and properly planned. They should be preceded by pilot projects, like the one suggested in the hypothesis, to determine their feasibility and avoid waste of resources. Aid can then be given to proven measures. The programmes should have short and long-term goals and be subjected to independent evaluation and monitoring. They should concentrate on finding practical solutions at the community level and should integrate all aspects of the problem, health, education, welfare, tradition, women and children's rights and development.

#### 5.2.2.3. Credibility:

For the people who perform female circumcision the tradition carries moral and religious meaning and is a symbol of reassurance and societal stability. Therefore in order to effectively a change a deeply rooted cultural practice, one must first of all aim towards becoming a trustworthy and credible force within the particular society or community. It is most important to accept the speed and specific pattern of change, to build on the

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<sup>60</sup>The methods that are used to end female circumcision must certainly be harmonious to the overall goal. There needs to be an inbuilt threshold, which in this case is represented by the difference of performing 'sunnah' circumcision (piercing of skin) as opposed to clitoridectomy (cutting of clitoris), a clear bodily mutilation incorporating the surgical removal of a healthy part of the body.



present indigenous understanding of people, to work through the current system and to even revitalize and make use of the communities own perceptions and attitudes. In condemning a cultural tradition<sup>61</sup> one immediately pulls oneself out of the process and ceases to build an influential force (Andreopolus 1996). Therefore the challenge to keep the long-term goal of ending female circumcision in mind and simultaneously hold on to a status of internal legitimacy is best met by giving local consenting voices a forum for expression and supporting their ideas and proposals for action. Likewise, dissenting voices might become allies if influential community leaders are encouraged to speak openly e.g. in the mosque, or the women's elders in the women's group meetings. Giving support and respect to internal onset of change is also the only sustainable solution.

#### 5.2.2.4. Men's participation:

The question of whether men should be included in finding solutions, or whether campaigns against circumcision are inevitably anti-male, has been answered diversely over time and can be concluded as follows: every struggle to end circumcision will most certainly be carried out against certain men and women and with certain men and women. In fact successful solutions for raising the status of women in society have to be found collective and international (Awa Thiam 1978 in: Dorkenoo 1994). My findings suggest that men are already and have probably always been a crucial part in working out solutions. The local men in the community clearly stated that they would like the "pharaohnic" type of circumcision to be replaced by the "sunnah" type. Therefore the

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<sup>61</sup>This is expressed in wordings like: eradication, abolishment, elimination





problem can not so much be defined as a gender-issue anymore than as a communication issue between the sexes. In both interviewed groups -- men and women -- the understanding of religious teachings was the strongest predictor for the change of perception towards traditional infibulation. This fact leads me to draw two assumptions. First, the education of the public in Koranic teachings might yield more promising results at present, especially among the rural population, than general education efforts (also, as most children attend Koran school, but are not necessarily enrolled in a regular school system). Second, the "sunnah ceremony center" would embody a physical and visible representation of change in the community that cannot easily be overlooked. It would most certainly encourage dialog within men and women's groups as well as across these groups. Influential male elders and religious leaders<sup>62</sup> could officially show their support and acceptance by speaking out for the center in public as well as by paying an initial visit and giving a ritual blessing at the day of inauguration.

#### 5.2.2.5. Women's Health goes beyond Maternal Health:

It is a fact that most women's health programs today are actually maternal child health programs. This might be a crucial factor towards slowing down the changes in circumcision practices. Changing the emphasis of women's health care to include currently

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<sup>62</sup>These groups are shown to have the greatest influence on public opinion, including health professionals. Religious institutions are found to play an important role in educating their communities and they further act as community surveillance (Raedda Barnen 1994).



neglected areas of gynecological, mental and non-maternity health needs of the woman as a person, not just as a mother, would help to encourage the ending of circumcision. The consideration of incorporating female genital mutilation into broader efforts to improve women's status and health, including their sexual and reproductive health, is not just a more comprehensive (and therefore favorable) approach, but could also help to avoid the isolation and stigmatization of women (Joint Statement 1995).

The physical location of the proposed "sunnah ceremony center" at the women's group meeting place, would remove all hindrances for the women to pay visits. It would be a place that is owned by the women, as they sustain it and have the decision making power<sup>63</sup> It is part of the women's community network and therefore non-alienating, low-threshold, peer-oriented, cooperative, open and designed to serve their needs<sup>64</sup> It further represents an architectural symbol of change in the community. The center could act as a clearing house for information, education, referral and treatment of a wide variety of reproductive health and other women's health problems. It would be the place where dialogue can get started, initiated by the women as well as the midwife. It would also be the place where first contacts with the 'high risk population' (young women and mothers with young daughters) can be established. Women can bond with others who go through the same struggles (question of whether to circumcise the daughter, living with reproductive health complications like fistulas or stitch neuromas, and many more). This

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<sup>63</sup>The nurse could, for example, be paid with the salary that usually goes to the circumciser.

<sup>64</sup>Which are all scientifically proven factors that make behavior change more likely to occur (Harmreduction 1995).



exchange would not just help to reduce the feeling of helplessness and uniqueness, but also help to maintain an ongoing awareness process. Psychological research has shown that consciousness raising is strongly reinforced by helping peer-relationships and behavior change is most likely to persist if change is seen as an ongoing continuum. In opposition to an eradication campaign which aims to eliminate a cultural practice, a harm-reduction approach aims to promote and protect people's physical and mental health, self-esteem and cultural belonging. Two main principle follow: First, if you remove something enormous from somebody's life, it must be replaced by something equally valuable to this person. This premise would be satisfied as the women would be provided with a safe, enclosed and protected place in which they can fulfill the cultural rituals of the traditional practice. Secondly, any steps towards decreased risks are steps in the right direction (Harmreduction 1995). The center's keypoint is to attract women to come and start a dialogue, to make the connection to the possibility for change and to identify and strengthen their readiness for change. So that women learn about the connection between infibulation and illness from each other and that they also learn to perceive their own health as a valuable good, for themselves and for the entire community<sup>65</sup>

#### 5.2.2.6. The special status of midwives:

Repeatedly research literature stresses the possible role of female nurses, as opposed to doctors, in the education process

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<sup>65</sup>This is a high priority in a region where access to family planning is as high as 5 percent and general fertility is 7,5. Please see chapter 3.1 for vital statistics.



"In African societies, nurses and midwives are highly respected since they provide the main source of health care to women and thus are seen as possessing the power of life and death" (Arbesman 1993, 36).

In general it shows that the practice and opinion of doctors, nurses and midwives on health care issues widely sets the standard within the communities (UNICEF Directive 1994).

This information carries a two-fold message. First, despite all efforts and many UN resolutions, hospitals, doctors, nurses and midwives are found to perform circumcisions, even infibulations (Dorkenoo 1994; Armstrong 1994). People in the communities are aware of this fact and they also know that only families with higher socio-economic standing can afford a 'safe' circumcision for their daughters (Dirie 1991). Thus the official attitude of denial of help and support by medical personnel might be what drives the practice underground and makes the operations increasingly unsafe and dangerous, as the findings of this research (increased use of syringes and pharmaceuticals by untrained personnel) demonstrate. One of the major arguments against medicalizing circumcision is the fear that if trained personnel were to execute circumcisions, it would add legitimacy to the practice. However circumcision is already legitimized because people are aware that professionally trained health personnel are performing circumcision for those who can afford it.

Secondly, the present findings show that medical personnel play an important role in the individual awareness process of women (see chapter 4.5.). Given the high acceptance of nurses and midwives and their proven impact in forming opinions in the communities, the position of the health professional in the "sunnah ceremony center"





ideally would be taken by a female midwife or nurse.



### 5.2.3. More Lessons Learned

\* Outlawing circumcision as a single measure does not seem to have been effective over time. The Sudanese law forbidding infibulation was enacted in 1946 by the colonial administration. In a study that was done in 1967, 80 percent of Sudanese women were still infibulated (Shandall 1967); another study in 1979 showed an infibulation prevalence of 84 percent (El-Dareer 1979). Today, it shows that 89 percent of women and girls are still infibulated. Legal action that is not accompanied at least by information and education programs is ineffective. Evidence even indicates that a rush to legislate without first generating enough social awareness against the practice increases resistance to change and may merely push it underground (Toubia IJGO 1994; Arbesman 1993; Aldeeb 1994). Advocacy with governments should not stop with laws, but should encourage the development of action plans to implement laws, policies and education programs (UNICEF Directive 1994). Advocacy also should aim to protect women from suffering more damage from criminal proceedings than from infibulation practice.

The women of the observed community favored the active implementation of the new policy on the status of women in Ethiopia in comparison of the legal punishment of their traditional practice.

\* Traditional Healers see traditional practices as lucrative sources of income that have to be sustained (Raedda Barnen 1994). In some areas, the profession of the circumciser is inherited from mother to daughter and the economic survival of the family



depends upon it. If the practice were to be eradicated, it would remove the family's only source of income. Accordingly, it has been repeatedly suggested to retrain women who practice excision as traditional birth attendants (Aldeeb 1994).

According to the findings in Jijiga, the creation of alternative job opportunities for circumciser, other than retraining them as health care workers, seems highly recommendable. This suggestion is based on the fact that circumciser are perceived to hold a low social status in the community and are in fact seen as "unclean" Midwives in contrast are viewed as possessing the power of life.

\* Foot-binding in China was only definitely stopped by a massive social and political revolution. This revolution replaced the many traditions that it had swept away by offering an entirely new social system which was revolutionary in many aspects: landownership, education, gender equality, etc. In a similar way disasters, civil wars, displacements seem to have an impact on traditions as they bring about fast societal changes (Dines 1980). During the Ethiopian civil war, which ended 1991 with the independence of Eritrea, the Eritrean People's Liberation Front occupied large areas of Ethiopia and successfully forbade female genital mutilation (among many other reforms) (Dorkenoo 1994). Similarly a survey recognized people's desire to conform to the status quo of the current practice of the tribe in the area that they had moved to. Oromos of Haraghe, for example, were found to have adopted infibulation from their Somali neighbors, whereas the other Oromos usually practice excision. The desire to conform seems to be directed towards earning the respect of the new community. Even though



there is at present not much knowledge about how long lasting these changes are, it might be worthwhile to be conscious about these "sensitive" moments that seem to favor openness for accelerated change.

\* Limited research and the lack of precise data seem to hinder successful action. Genital mutilation is in no way as visible and obvious as limb amputations or mass starvation. It is also a subject concerning the most intimate patterns of a society. "Since there are no data or records of the distress and dangers caused by the operations, it is difficult to convince people as to the urgency of dealing with it" (Ogunmodede in: Dorkenoo 1994, 15). Therefore it has been repeatedly suggested that a comprehensive base-line study on the knowledge, attitudes and practices of people with regard to female circumcision in Ethiopia needs to be done. It is crucial to identify precisely the various beliefs attached to the traditional practice (Raedda Barnen 1994).

To apply this recommendation actively it can be suggested that the nurse or midwife in the "sunnah ceremony center" is responsible for basic data collection.

Evaluation materials can be prepared at start and part of the planning procedure. As the midwife is bound to have daily discussion and consultations, she is most likely to acquire detailed insight into people's own attitudes and perceptions. In my opinion several themes should be especially considered: What aspects of information or education bring most changes in perception? How is it most successfully transmitted? Are these changes lasting? Is there peer-education and is it successful? Which mechanism exactly causes effective change in behavior?





## 6. Conclusion

As the findings of this study show, infibulation is still the most prevalent form of female genital mutilation among the Somali population in Somali National State of Ethiopia. The practice is deeply imbedded in Somali culture and has a strong religious connotation. Parents actually feel it is their duty to protect their daughter's physical and moral integrity by infibulating them. Whatever incidence caused the initial creation of awareness among the participants -- mostly physical pain and illness for women and poor health of wives, as well as seeing an infibulation ceremony, for men -- the understanding of religious teaching can be seen as the strongest predictor for change. The findings of this study show that both men and women seem to be prepared to exchange the traditional practice of infibulation for "sunnah" circumcision, as they perceive the "sunnah" type as the one favored by the Koran and the teachings of Prophet Mohammed. This research reveals further that it is lack of inter-gender communication which keeps men and women from realizing that they are both already willing to change their cultural practice, settle for a middle-ground solution and support each others ideas. Based on their expressed willingness for change, the women suggested the establishment of a "sunnah" ceremony center, attached to the women's group meeting place and run by a professionally trained midwife.



The international formulation of a new circumcision policy is urgently needed in order to legitimize and encourage the development of practical programs, like the one suggested, that are actively designed, created and operated by indigenous people at grass-roots level. In order to stimulate the process, the following ethical and human rights concerns towards "eradication" strategies against female genital mutilation, the way they are currently executed by UN agencies and international organizations, are addressed:

1. Education, information and awareness raising, as executed by UN agencies and international organizations, can only be seen as a first and not solely sufficient step towards ending infibulation. There is an urgent need for practical programs on the community level.
2. The only ethically acceptable interventions are those which originate from within the culture. Paternalism towards African culture and its values was and is still practiced by social, political and economic means. The unwillingness of Western agencies to listen to local voices and their suggestions means that culturally appropriate and sensitive proposals for social change often go unheard.
3. Female infibulation has to be seen in its socio-cultural, economic and gender context, if successful intervention strategies are to be developed. The findings of this research show that even if people do understand the harmfulness of their tradition, they still keep believing in its cultural value. Thus, effective efforts towards the ending of FGM must go



beyond the medical model of disease eradication. Eradication of one cultural practice might easily eradicate other favorable aspects of the cultural tradition and harm could be done by evoking changes in fundamental societal patterns, such as male-female relationships, changing attitude towards elders and children, changing attitudes towards family and community values, changes in religious beliefs, stigmatization and traumatization of already infibulated women, widening the disparity between the urban/rural population and higher and lower socio-economic groups, etc. Possibilities for replacing the traditional custom with non-harmful alternatives have to be considered in order to favor a continuation of the important and positive aspects of the cultural tradition.

Arguments in favor of a step-by-step approach, on the other hand, can be formulated as follows:

1. A political advocacy role in mandating and assisting local voices, even outside their own reach, would be taken by supporting their idea of a "sunnah" ceremony center.
2. Finding practical solutions and working in incremental steps, as shown by the establishment of the "sunnah center", can be perceived as strategies which in fact more actively respect and apply international human rights.
3. In order to effectively transform a deeply rooted cultural practice, one must aim



towards becoming a trustworthy and credible force within the particular culture. It is important to accept the speed and specific pattern of change, to build on the present indigenous understanding of people, to work through the current system and to even revitalize and make use of the community's own perceptions and attitudes.

4. Men, especially religious elders and other influential community leaders, play a crucial part in supporting the implementation of the "sunnah center" Their support is based on their religious understanding that according to the sayings of the Koran, infibulation should be replaced by the "good" and religiously favored practice of "sunnah" circumcision.

5. The consideration of incorporating female genital mutilation into broader efforts (sexual and reproductive health, gynecological, mental and non-maternity health), as planned in the "sunnah center", will improve women's status and health overall.

6. Midwives are seen as possessing the power of life and therefore could function as an integral part of opinion forming by informing the population, performing the religiously perceived "sunnah" circumcision and decreasing inequality as all women will have access to her services. Thus, the position of professionally trained medical personnel in the performance of "sunnah" circumcision only and under specifically outlined project conditions has to be re-evaluated. The same reasoning used for doing male circumcision in a professional and safe environment should be applied to women. In both cases the use





of medical personnel ensures the health and well-being of the patient. This step has to be preceded by drawing internationally agreed distinctions between different types of female circumcision -- cutting of healthy organs versus ritual performance of a traditional rite which does not involve cutting -- and between female and male circumcision. Decisive criteria must be in place to ensure that any form of mutilation does not interfere with the application of human rights. The strongest of these criteria must be whether the act itself contributes to the overall goal of ending any form of mutilation.



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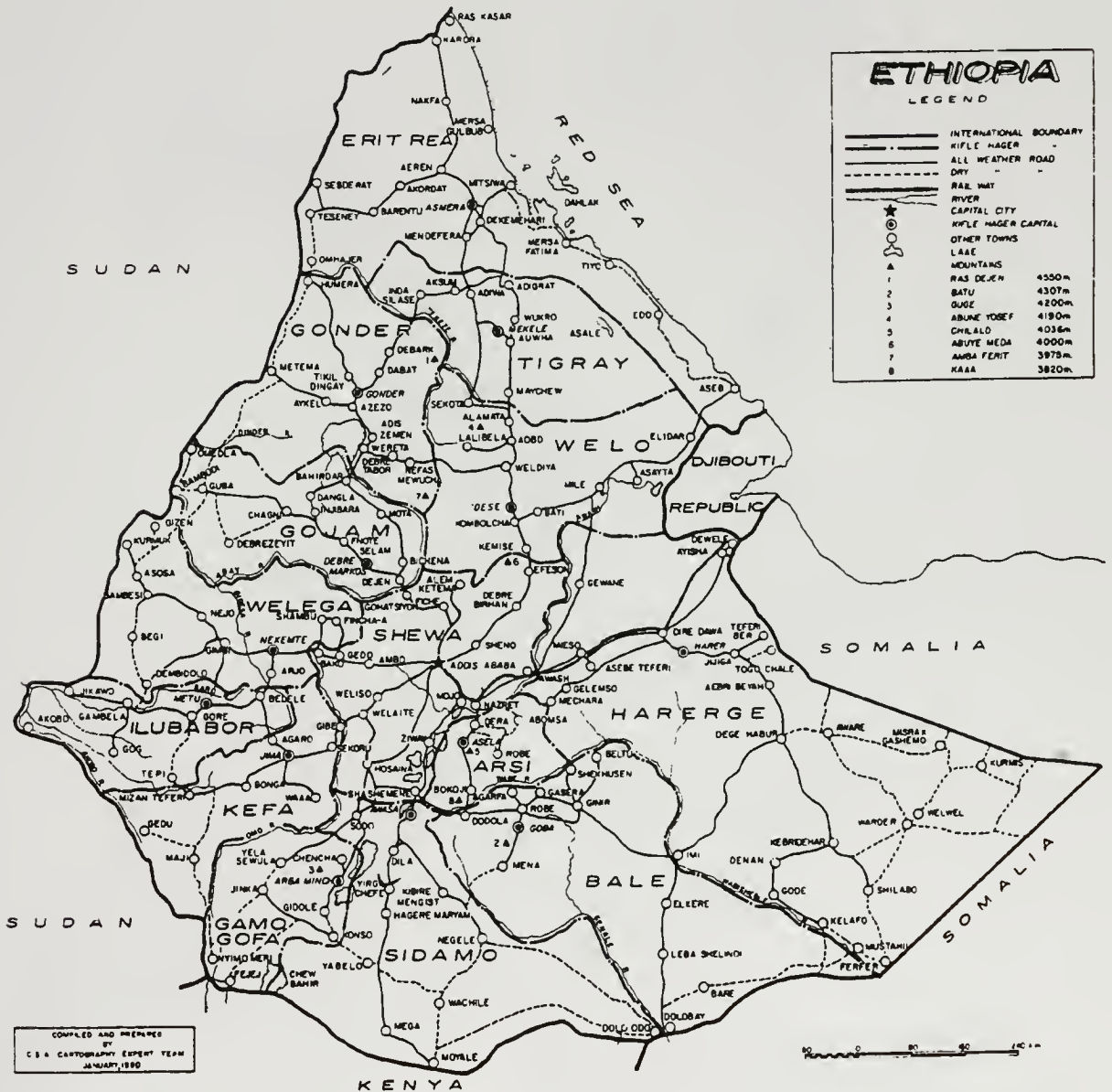


## Appendix A

**Figure 1**

### Map of Ethiopia

Source: Central Statistical Authority 1990







**Figure 2**

Representation of the 9 zones of Somali National State

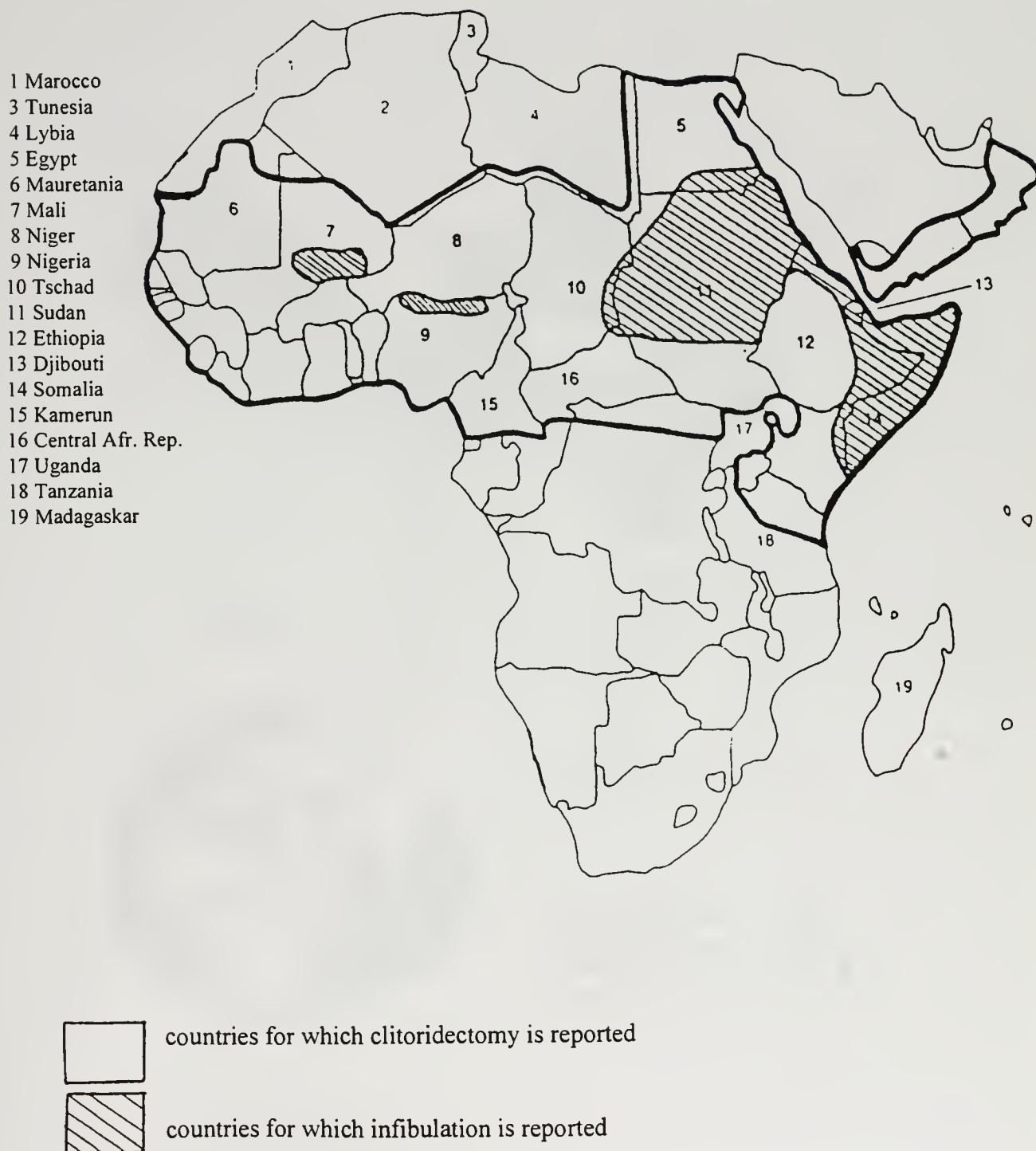
Source: Central Statistical Authority 1990





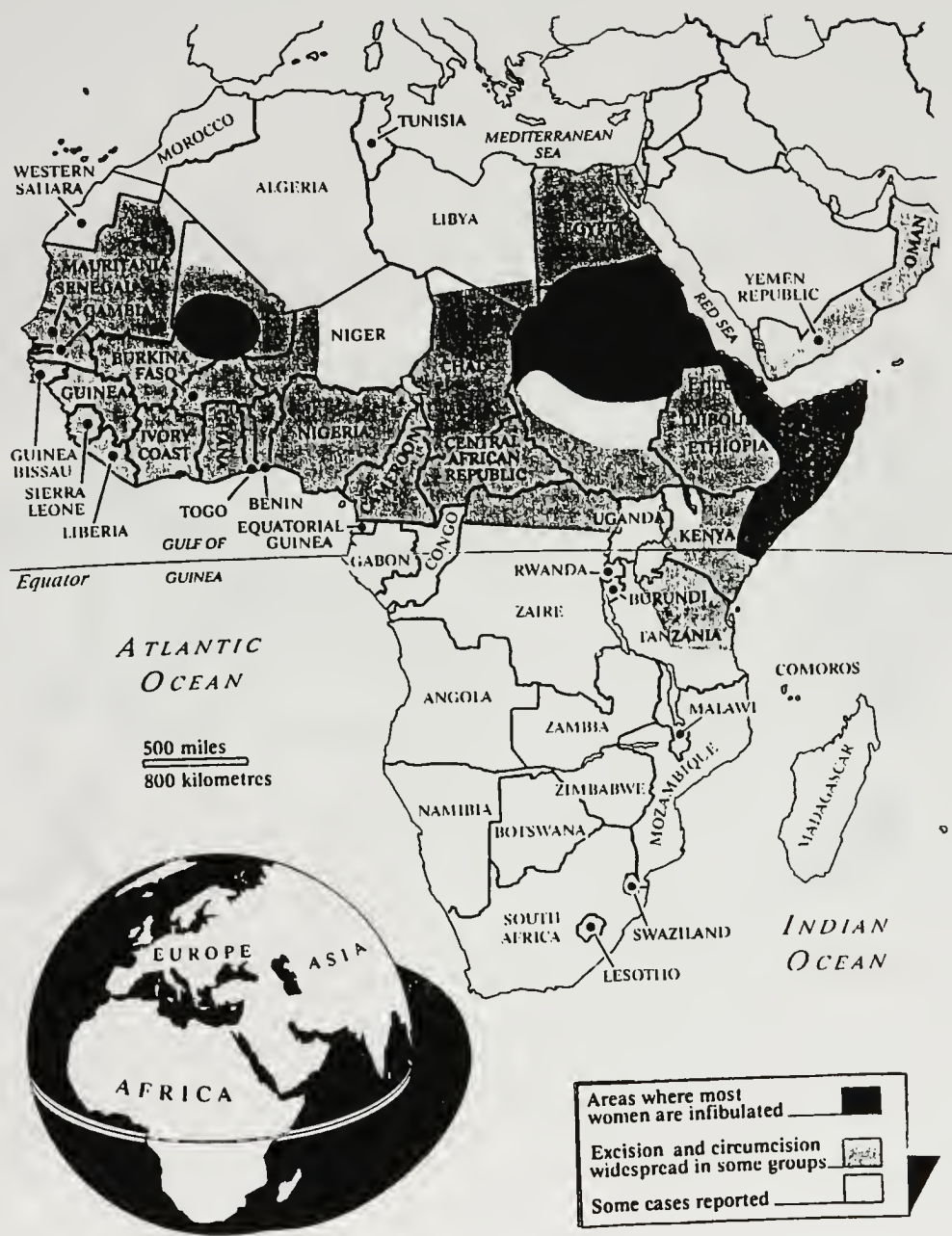
**Figure 3**  
**Countries affected by Female Circumcision**

Source: Reyners 1993





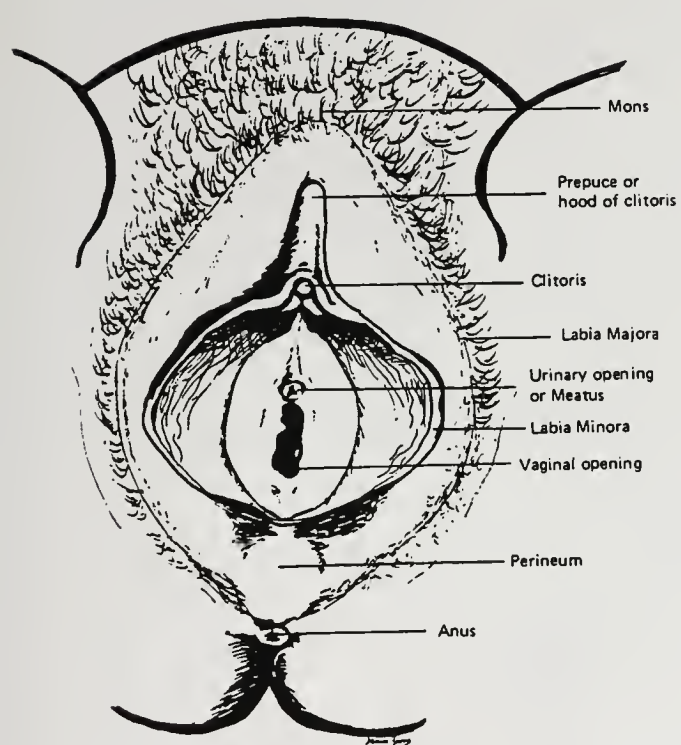
**Figure 4**  
**Case Distribution of Female Infibulation**  
Source: Dorkenoo 1994





**Figure 5****Normal Adolescent Vulva (in extension) and Infibulated Vulva**

Source: Dorkenoo 1994



Normal Adolescent Vulva  
in extension



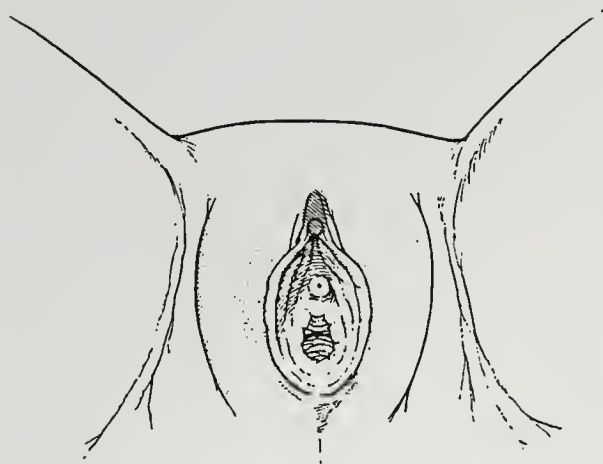
Infibulated Vulva





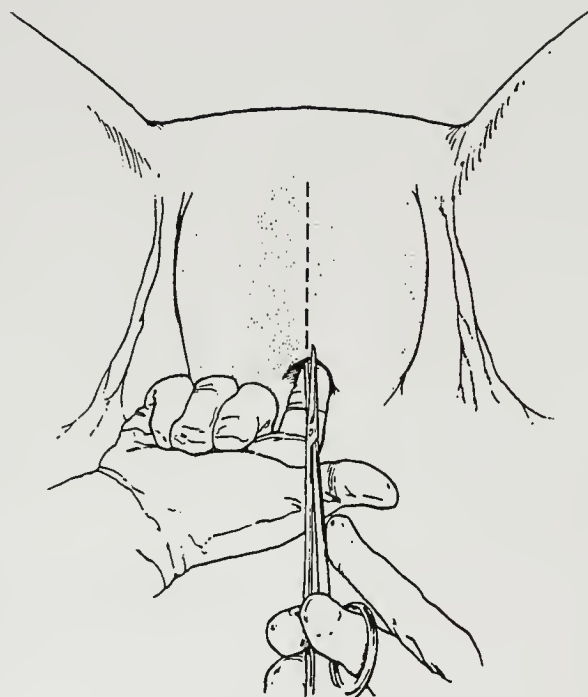
**Figure 6****Clitoridectomy Type 1 and 2, Deinfibulation and Stitching after Deinfibulation**

Source: Toubia, NEJM, 1994

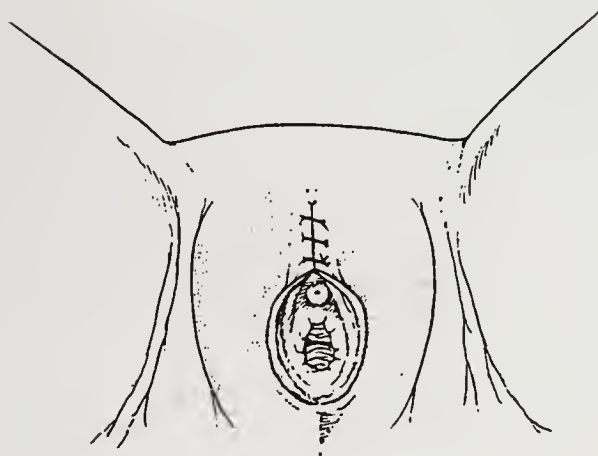
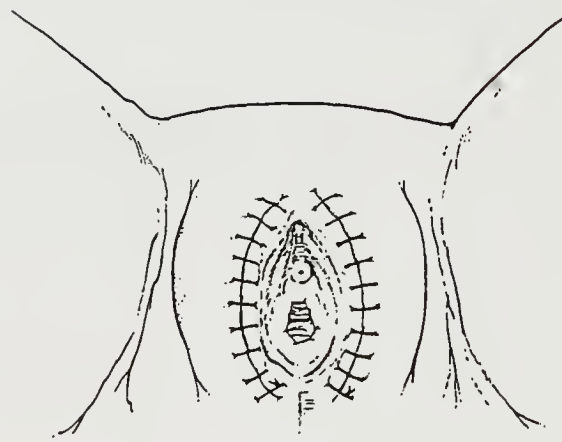


Type I Clitoridectomy.

The hatched area indicates the tissue to be removed.



Deinfibulation Procedure.

Type II Clitoridectomy (Excision) after Hemostatic  
Stitching.

Hemostatic Stitches after Deinfibulation.



## Appendix B

**Table 1**

**Population and Health Data for Ethiopia**

Source: \*Human Development Report 1995; \*\*UNICEF 1995; Worldmark 1995

|   |   |
|---|---|
| Estimated population size in 1995                                     | 56,5 million  |
| Life expectancy at birth (years)                                      | 47,5*   |
| GNP per capita for Ethiopia in US \$ 1993                             | 100**   |
| Percentage of foreign aid of all central government revenues 1994     | 37**  |
| Public expenditure on health (as % of GNP) in 1990                    | 2,3*  |
| National per capita consumption of water per day                      | 10 litres   |
| Access to safe water  | rural population: 12%<br>urban: 70%<br>total: 25%*  |
| National sanitation coverage  | 7%  |
| Adult literacy rate   | 32,7%*  |
| Houses more than one-day walk from nearest (unpaved) road             | 75%   |
| Population engaged in agriculture, hunting, fishing, forestry in 1984 | 90% (Animal husbandry -- cattle, sheep, goats, donkeys and camels -- provides a living for 75% of the population) <sup>66</sup> |
| Mass of fertile land versus actually cultivated land                  | 70% versus 12,7%  |

[According to the human development index (HDI) Ethiopia ranks 171 out of 174 countries (Human Development Report 1995)]

<sup>66</sup>Ethiopia has the largest livestock population in Africa (Worldmark 1995)



**Table 2****Population Data for Hararge Region in 1984**

Source: Population and Housing Census 1984

|  |  |
|--|--|
| Population under 15 years of age                                   | 48,7%  |
| Population between age 15 and 64                                   | 47,9%  |
| Population 65 years and above                                      | 3,4%   |
| Population between years 0-24 (children and young adults together) | 63%  |
| Median age of population   | 15,8 years   |
| Burden of dependency   | 100 persons in the ages 15-59 years support 120 dependents                             |
| Sex ratio  | 105,5 males to 100 females   |
| Percentage of population living in rural areas                     | 90%  |
| Expectation of life at birth males/females                         | rural: 47,2 years/48,5 years<br>urban: 49,3 years/52,2 years<br>total: 47,3 years/48,8 |



**Table 4**  
**Selected Indicators in Comparison**

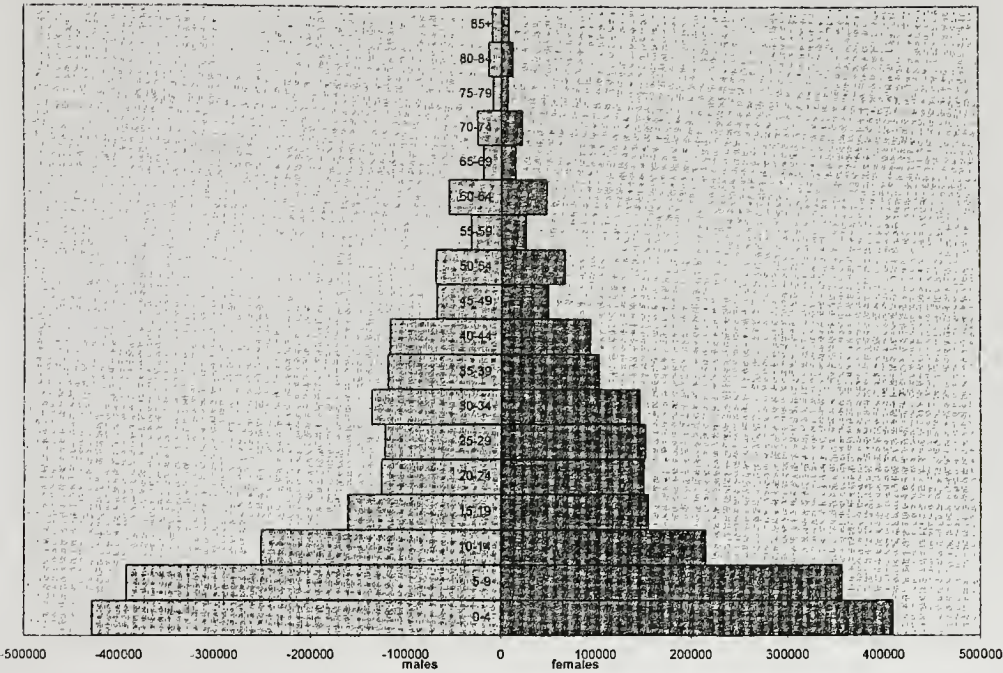
Source: \*Human Development Report 1995; Population and Housing Census 1984; Transitional Government 1995

| Rates  | Hararge Region<br>(Pop. Census 1984)                                  | <u>Ethiopia</u><br>(Transitional gov.1995) |
|--|---|--|
| Crude Birth Rate (per 1000)                    | <u>total:</u> 43,7<br>rural: 45,5<br>urban: 31,8                      | <u>total:</u> 46,7                         |
| Total Fertility Rate<br>(children per woman)   | <u>total:</u> 7,02<br>rural: 7,37<br>urban: 4,92                      | <u>total:</u> 7,5                          |
| Crude Death Rate (per 1000)                    | <u>total:</u> 8,5<br>rural: 8,7<br>urban: 6,6                         | <u>total:</u> 17,9                         |
| Rate of Natural Increase<br>(CBR-CDR)          | <u>total:</u> 35,2<br>rural: 36,8<br>urban: 25,2                      | <u>total:</u> 28,8                         |
| IMR (Infant Mortality Rate, <1 year)           | <u>total:</u> 132/1000 LB<br>rural: 133/1000 LB<br>urban: 117/1000 LB | <u>total:</u> 119/1000 LB*                 |
| Under-five-mortality rate in                   | no data   | <u>total:</u> 204/1000 LB*                 |
| MMR (Maternal Mortality Rate per 100.000 LB)   | no data   | 560/100.000 LB                             |
| Number of Deaths/<br># of deaths age 0-1 years | <u>total:</u> 22,790/6,061<br>rural: 20,557/5,478<br>urban: 2,233/583 | no data                                    |
| Contraceptive prevalence rate (any method)     | no data   | 4%   |
| Women who deliver by trained personnel         | no data   | 14%*                                       |
| Pregnant mothers receiving antenatal care      | no data   | 15%  |
| Underweight children under age five in 1990    | no data   | 40%*                                       |





**Table 3**  
**Population Pyramid for Hararge Region 1984**  
Source: Population and Housing Census 1984





**Table 5****Health Resources in Ethiopia**

Sources: WHO 1980; Transitional Gov. 1995; MoH - Ministry of Health 1984; Kloos 1987; Munzinger 1994

| <u>Health Establishments</u> | 1977 (WHO '80) | 1983 (MoH '84) | 1987 (Munzinger '94) | 1994 (Trans. Gov.'95) |
|------------------------------|----------------|----------------|----------------------|-----------------------|
| Hospitals                    | 84             | 84             | 100                  | 72                    |
| Hospital beds                | 8746           | 11479          | 11400                | 9538                  |
| Health centers               | 106            | 130            | 159                  | 153                   |
| Health stations              | 1010           | 1850           | 2095                 | 2094                  |

| <u>Medical Personnel</u> | 1977 (Munzinger '94) | 1984 (Kloos. 1987) | 1994 (Trans. Gov. '95) |
|--------------------------|----------------------|--------------------|------------------------|
| Physicians               | 396                  | 729                | 2214                   |
| Pharmacists              | 172                  | 367                | 650                    |
| Nurses                   | 1488                 | 1960               | 5000                   |
| Health assistants        | 4397                 | 6991               | 13500                  |
| Community health workers | 0                    | 4500               | ---                    |

[Please note that the numbers for both tables in all categories were taken from different sources. It might not be legitimate to make direct comparisons. Through different political periods various position descriptions were renamed (in 1994 "health assistants" might include "community health workers")]

**Table 6****Health facilities in Somali National State**

Source: Transitional Government 1995

| Region                | Hospitals | Beds | Health Centers | Health Stations |
|-----------------------|-----------|------|----------------|-----------------|
| Somali National State | 3         | 206  | 4              | 88              |



**Table 7****Number of Health Workers per Population Ratio in 1994**

Source: Transitional gov. 1995; \*Human Development Report 1995.

|                        |                     |
|------------------------|---------------------|
| Medical doctors        | 1:24,841; 1:33,333* |
| Nurses                 | 1:11,000; 1:14,286* |
| Health Assistants      | 1:4,074             |
| Laboratory Technicians | 1:61,111            |
| Pharmacists            | 1:84,615            |
| Druggist               | 1:119,565           |
| Radiographers          | 1:176,848           |
| Sanitarian             | 1:80,058            |

[Traditional medicine still remains the major source of care for an estimated 80 percent of the population and the usage of traditional healers as well as herbal home remedies is grossly under reported. Furthermore many lay and poorly trained practitioners, called "injectionists", operate outside the official health care system but obtain their drugs from commercial drug retailers. These traditional medical systems function largely in secrecy and constitute important elements to the health system. Professionally trained health professionals tend to concentrate in urban areas and there is a mismatch between trained professionals and health facilities, resulting in an extraordinary situation whereby doctors are underutilized in a country with one of the lowest professionals to population ratios. Additionally an estimated 31% of health facilities need major repairment or replacement (Transitional Government 1995)]













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